HFS 15

Relating to assessments on occupied, licensed beds in nursing homes and intermediate care facilities for the mentally retarded.

The Department of Health and Family Services requests and extension of the effective period of this emergency rule for 8 days.

Second Consideration

State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

November 17, 2003

The Honorable Glenn Grothman, Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 15 North, State Capitol
P.O. Box 8952
Madison, Wisconsin 53708-8952

The Honorable Joseph Liebham, Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 409 South, State Capitol
P.O. Box 7882
Madison, Wisconsin 53707-7882

Dear Representative Grothman and Senator Leibham:

The Department of Health and Family Services has an emergency rulemaking order in effect that will expire before the emergency rules are replaced by permanent rules unless the effective period of the emergency order is extended. Pursuant to s. 227.24 (2), Stats., I ask the Joint Committee to extend the effective period of the emergency order by **60 days** as indicated below. The emergency rules are as follows:

The emergency rulemaking order amending ch. HFS 15 was published and effective on **July 28, 2003**, and **will expire on December 24, 2003**, unless extended.

Replacement permanent rules were sent to the Legislative Council for review on August 25th and were the subject of a combined (emergency and proposed permanent) public hearing held on October 15th. No one attended the hearing and the Department did not receive any public comments on the rules. The Department recently sent the Legislative Report to the Presiding Officers of the Senate and Assembly. Consequently, the Department will not be able to file the rules until at least late December for a February or March 1st effective date. Therefore, I request an extension of the effective period of the emergency rules by **60 days**, through February 22, 2004. If the effective period of the emergency rules is not extended, in the interim, the Department will not have the authority to collect the fees from long-term care facilities.

A copy of the emergency rulemaking order is attached to this letter. If you have any questions about the rules, you may contact C. David Lund, in the Division of Health Care Financing at 266-2021.

Sincerely,

Helene Nelson
Secretary

Attachment(s)

cc Senator Alan Lasee
Speaker John Gard

State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

January 16, 2004

The Honorable Glenn Grothman, Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 15 North, State Capitol
P.O. Box 8952
Madison, Wisconsin 53708-8952

The Honorable Joseph Liebham, Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 409 South, State Capitol
P.O. Box 7882
Madison, Wisconsin 53707-7882

Dear Representative Grothman and Senator Leibham:

The Department of Health and Family Services has an emergency rulemaking order in effect that will expire before the emergency rules are replaced by permanent rules unless the effective period of the emergency order is extended. Pursuant to s. 227.24 (2), Stats., I ask the Joint Committee to extend the effective period of the emergency order by **8 days** as indicated below. The emergency rules are as follows:

The emergency rulemaking order amending ch. HFS 15 was published and effective on **July 28, 2003**, and **will expire on February 22, 2004**, unless extended.

Neither assigned legislative standing committee commented on the final proposed permanent rule order. Consequently, the Department filed the replacement permanent rules on January 12, 2004. Given that the permanent rules will not take effect until March 1st, I request an extension of the effective period of the emergency rules by **8 days**, through February 29, 2004. If the effective period of the emergency rules is not extended, in the interim, the Department will not have the authority to collect the fees from long-term care facilities.

A copy of the emergency rulemaking order is attached to this letter. If you have any questions about the rules, you may contact C. David Lund, in the Division of Health Care Financing at 266-2021.

Sincerely,

Helene Nelson
Secretary

Attachment

SENATOR JOSEPH LEIBHAM
CO-CHAIR

P.O. BOX 7882
MADISON, WI 53707-7882
(608) 266-2056

REPRESENTATIVE GLENN GROTHMAN
CO-CHAIR

P.O. BOX 8952
MADISON, WI 53708-8952
(608) 264-8486

JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES

Emergency Rule Extension Motion Form

January 21, 2004
State Capitol

Moved by Leibham, Seconded by Gunderson

THAT, pursuant to s. 227.24(2)(a), stats. the Joint Committee for Review of Administrative Rules extends the effective period of emergency rule Chir 2 for 60 days and HFS 15 for 8 days at the requests of the Department of Regulation and Licensing on behalf of the Chiropractic Examining Board, and the Department of Health and Family Services.

COMMITTEE MEMBER	Aye	No	Absent
1. Senator LEIBHAM	✓		
2. Senator WELCH	✓		
3. Senator LAZICH	✓		
4. Senator ROBSON	✓		
5. Senator COGGS			
6. Representative GROTHMAN	✓		
7. Representative SERATTI			
8. Representative GUNDERSON	✓		
9. Representative BLACK	✓		
10. Representative HEBL	✓		
Totals			

☐Motion Carried ☐Motion Failed

Health and Family Services – Affects Ch. HFS 15

SECTION 1. HFS 15.01 is amended to read:

HFS 15.01 Authority and purpose. This chapter is promulgated under the authority of s. 50.14 (5) (b), Stats., to ~~establish~~ procedures and other requirements necessary for levying and collecting the monthly assessment imposed under s. 50.14 (2), Stats., on all ~~occupied,~~ licensed beds in intermediate care facilities for the mentally retarded (ICF-MR) and nursing homes, except facilities that are ~~owned and operated by state government or the federal government or~~ located outside the state~~, or beds occupied by residents whose care is reimbursed in whole or in part by medicare under 42 USC 1395 to 1395ccc~~.

SECTION 2. HFS 15.02 (2), (6) and (8) are repealed.

SECTION 3. HFS 15.03 is repealed and recreated to read:

HFS 15.03 Facilities not subject to assessment. Facilities located outside the state are excluded from assessments imposed under this chapter and s. 50.14, Stats.

SECTION 4. HFS 15.04 is amended to read:

HFS 15.04 Assessment calculation. (1) ASSESSMENT. Every facility ~~which~~ that is not excluded under s. HFS 15.03 ~~(1)~~ shall pay an assessment per ~~occupied~~ licensed bed as prescribed by s. 50.14, Stats., and as calculated pursuant to this section and s. 50.14, Stats. The amounts of the assessment per ~~occupied~~ licensed bed shall be as specified by s. 50.14, Stats.

(2) CALCULATION. (a) The assessment shall be on the ~~average~~ number of ~~occupied,~~ licensed beds of the facility ~~for~~ on the 15th day of the calendar month previous to the month of assessment, ~~based on an average daily midnight census computed and reported by the facility and~~ as verified by the department. ~~Beds for which payment is made by medicare under 42 USC 1395 to 1395ccc shall be excluded from the calculation. A bed occupied by a person who is eligible for both medicare and medicaid, and for which medicare pays a portion of the room and board for the person, is excluded from the calculation.~~

(b) 1. In determining the number of ~~occupied,~~ licensed beds, if the number of beds is other than a whole number, the fractional part of the amount shall be disregarded unless it equals 50% or more of a whole number, in which case the amount shall be increased to the next whole number.

2. The number of licensed beds of a nursing home includes any number of beds that have been delicensed under s. 49.45 (6m) (ap) 1., Stats., but not deducted from the nursing home's licensed bed capacity under s. 49.45 (6m) (ap) 4. a., Stats.

(c) In a facility having some beds that are licensed as ICF-MR beds and some beds that are licensed as nursing home beds, separate calculations shall be performed for the ICF-MR beds and for the nursing home beds. ~~The bed of a person with a developmental disability as defined under s. HFS 132.13 (4) or 134.13 (9) who is a resident of a nursing home shall be assessed at that facility's rate, while the bed of a resident who is not developmentally disabled but who is residing in an ICF-MR shall be assessed at the ICF-MR rate.~~

SECTION 5. HFS 15.07 (3) is amended to read:

HFS 15.07 (3) If the department determines that a facility's ~~bed calculation is inaccurate~~ number of licensed beds has changed, the department shall notify the facility of ~~any~~ changes in the number of beds and ~~calculation or~~ assessment and shall send the facility an invoice for the additional amount due or send the facility a refund. Any additional amount due shall be paid by the facility no later than 30 days following the date of the department's notice.

SECTION 6. INITIAL APPLICABILITY. Pursuant to s. 9324 (4) of 2003 Wisconsin Act 33, the treatment of ss. HFS 15.01 to 15.04 first apply to assessments due on July 1, 2003.

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

EXEMPTION FROM FINDING OF EMERGENCY

The legislature by section 9124 (3) (b) of 2003 Wisconsin Act 33 provides an exemption from a finding of emergency for the adoption of the rule.

Analysis Prepared by the Department of Health and Family Services

2003 Wisconsin Act 33 modified section 50.14 of the Wisconsin statutes, relating to assessments on occupied, licensed beds in nursing homes and intermediate care facilities for the mentally retarded (ICF-MR.)

Under section 50.14 of the Wisconsin Statutes, nursing facilities (nursing homes and ICF-MRs) are assessed a monthly fee for each occupied bed. Facilities owned or operated by the state, federal government, or located out of state are exempt from the assessment. Beds occupied by a resident whose nursing home costs are paid by Medicare are also exempt. The rate, specified in section 50.14 (2) of the statutes, was $32 per month per occupied bed for nursing homes and $100 per month per occupied bed for ICF-MRs.

2003 Wisconsin Act 33 made the following changes to section 50.14:

1. It broadened the scope of which types of long-term care facilities must pay a monetary assessment to the Department by:

- eliminating exemptions from being subject to the assessments of facilities owned or operated by the state or federal government, and beds occupied by residents whose care is reimbursed in whole or in part by medicare under 42 USC 1395 to 1395ccc; and
- eliminating the exclusion of unoccupied facility beds from facility bed count calculations.

2. It increased the per bed fee limit the Department may charge subject ICF-MRs, from $100 per bed to $435 per bed in fiscal year 2003-04 and $445 per bed in fiscal year 2004-05.

3. It increased the per bed fee limit the Department may charge subject nursing homes, from $32 per bed to $75 per bed.

4. It establishes the requirement that amounts collected in excess of $14.3 million in fiscal year 2003-04, $13.8 million in fiscal year 2004-05, and, beginning July 1, 2005, amounts in excess of 45% of the amount collected be deposited in the Medical Assistance Trust Fund.

5. It specifies that facility beds that have been delicensed under section 49.45 (6m) (ap) 1. of the statutes, but not deducted from the nursing home's licensed bed capacity under section 49.45 (6m) (ap) 4. a., are to be included in the number of beds subject to the assessment.

In response to these statutory changes, by this order, the Department is modifying chapter HFS 15 accordingly.

The Department is also proceeding with promulgating these rule changes on a permanent basis through a proposed permanent rulemaking order.

ORDER

Pursuant to the authority vested in the Department of Health and Family Services by s. 50.14 (5) (b) and s. 9124 (3) (b) of 2003 Wisconsin Act 33, the Department of Health and Family Services hereby repeals, amends, and repeals and recreates rules interpreting s. 50.14, Stats., as follows:

SECTION 1. HFS 15.01 is amended to read:

HFS 15.01 Authority and purpose. This chapter is promulgated under the authority of s. 50.14 (5) (b), Stats., to establish procedures and other requirements necessary for levying and collecting the monthly assessment imposed under s. 50.14 (2), Stats., on all ~~occupied,~~ licensed beds in intermediate care facilities for the mentally retarded (ICF-MR) and nursing homes, except facilities that are ~~owned and operated by state government or the federal government or~~ located outside the state~~, or beds occupied by residents whose care is reimbursed in whole or in part by medicare under 42 USC 1395 to 1395ccc~~.

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(2) CALCULATION. (a) The assessment shall be on the ~~average~~ number of ~~occupied,~~ licensed beds of the facility ~~for~~ on the 15th day of the calendar month previous to the month of assessment, ~~based on an average daily midnight census computed and reported by the facility and~~ as verified by the department. ~~Beds for which payment is made by medicare under 42 USC 1395 to 1395ccc shall be excluded from the calculation. A bed occupied by a person who is eligible for both medicare and medicaid, and for which medicare pays a portion of the room and board for the person, is excluded from the calculation.~~

(b) 1. In determining the number of ~~occupied,~~ licensed beds, if the number of beds is other than a whole number, the fractional part of the amount shall be disregarded unless it equals 50% or more of a whole number, in which case the amount shall be increased to the next whole number.

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(c) In a facility having some beds that are licensed as ICF-MR beds and some beds that are licensed as nursing home beds, separate calculations shall be performed for the ICF-MR beds and for the nursing home beds. ~~The bed of a person with a developmental disability as defined under~~

~~s. HFS 132.13 (4) or 134.13 (9) who is a resident of a nursing home shall be assessed at that facility's rate, while the bed of a resident who is not developmentally disabled but who is residing in an ICF-MR shall be assessed at the ICF-MR rate.~~

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HFS 15.07 (3) If the department determines that a facility's ~~bed calculation is inaccurate~~ number of licensed beds has changed, the department shall notify the facility of ~~any~~ changes in the number of beds and ~~calculation or~~ assessment and shall send the facility an invoice for the additional amount due or send the facility a refund. Any additional amount due shall be paid by the facility no later than 30 days following the date of the department's notice.

SECTION 6. INITIAL APPLICABILITY. Pursuant to s. 9324 (4) of 2003 Wisconsin Act 33, the treatment of ss. HFS 15.01 to 15.04 first apply to assessments due on July 1, 2003.

The rules contained in this order shall take effect as emergency rules upon publication in the official state newspaper as provided in s. 227.24 (1) (c), Stats.

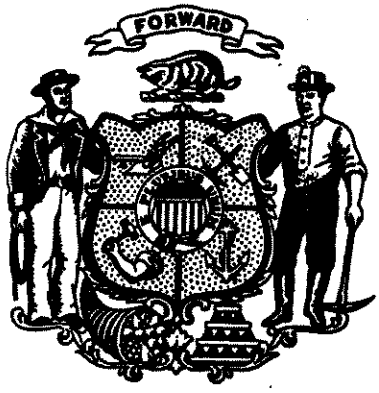
Wisconsin Department of Health
and Family Services

Dated: July 24, 2003

By: _____ for
Helene Nelson
Secretary

SEAL:

END



END

HFS 101...

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

OFFICE OF LEGAL COUNSEL

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P.O BOX 7850
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www.dhfs.state.wi.us

January 30, 2003

The Honorable Joseph Leibham, Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 409 South, State Capitol
Madison, Wisconsin

The Honorable Glenn Grothman, Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 15 North, State Capitol
Madison, Wisconsin

Dear Senator Leibham and Representative Grothman:

This is notification that tomorrow the Department of Health and Family Services will publish an emergency rulemaking order to modify chs. HFS 101, 102, 103, 104 and 107, implementing the federal Medicaid waiver the Department received to use Medicaid funds to expand Medicaid services by providing coverage of family planning services for females of child-bearing age who would not otherwise be eligible for Medicaid coverage. The program that will begin on February 1, 2003 is known as the Medicaid Family Planning Demonstration Project. A copy of the emergency order is attached to this letter.

The amended rules are being published by emergency order to so the rules take effect in February 2003, rather than at the later date required by promulgating permanent rules. In so doing, the Department can provide health care coverage already authorized by the federal Center for Medicare and Medicaid Services as quickly as possible to women currently not receiving family planning services and unable to pay for them. The Department intends to immediately follow this emergency rule with an identical proposed permanent rulemaking order.

If you have any questions about this emergency rulemaking order, please contact Jim Vavra of the Division of Health Care Financing at 261-7838.

Sincerely,

Larry Hartzke
Administrative Rules Manager

Attachment

ORDER OF THE
DEPARTMENT OF HEALTH AND FAMILY SERVICES
AMENDING AND CREATING RULES

FINDING OF EMERGENCY

The Department of Health and Family Services finds that an emergency exists and that the rules are necessary for the immediate preservation of the public peace, health, safety or welfare. The facts constituting the emergency are as follows:

On June 25, 1999, the Department submitted a request for a waiver of federal law to the Centers for Medicare and Medicaid Services (CMS), the agency within the United States Department of Health and Human Services that controls states' use of Medicaid funds. On June 14, 2002, the Centers for Medicaid and Medicare granted the waiver, effective January 1, 2003. The waiver allows the state to expand Medicaid services by providing coverage of family planning services for females of child-bearing age who would not otherwise be eligible for Medicaid coverage. Under the waiver, a woman of child-bearing age whose income does not exceed 185% of the federal poverty line will be eligible for most of the family planning services currently available under Medicaid, as described in s. HFS 107.21. Through this expansion of coverage, the Department hopes to reduce the number of unwanted pregnancies in Wisconsin.

Department rules for the operation of the Family Planning Demonstration Project must be in effect before the program begins. The program statute, section 49.45 (24r) of the statutes, became effective on October 14, 1997. It directed the Department to request a federal waiver of certain requirements of the federal Medicaid Program to permit the Department to implement the Family Planning Demonstration Project not later than July 1, 1998, or the effective date of the waiver, whichever date was later. After CMS granted the waiver, the Department determined that the Family Planning Demonstration Project could not be implemented prior to January 1, 2003, and CMS approved this starting date. Upon approval of the waiver, the Department began developing policies for the project and subsequently the rules, which are in this order. The Department is publishing the rules by emergency order so the rules take effect in February 2003, rather than at the later date required by promulgating permanent rules. In so doing, the Department can provide health care coverage already authorized by CMS as quickly as possible to women currently not receiving family planning services and unable to pay for them. The Department is also proceeding with promulgating these rule changes on a permanent basis through a proposed permanent rulemaking order.

ORDER

Pursuant to the authority vested in the Department of Health and Family Services by ss. 49.45 (10) and 227.24 (1), Stats., the Department of Health and Family Services hereby amends and creates rules interpreting s. 49.45 (24r), Stats.

SECTION 1. HFS 101.03 (63m) is created to read:

HFS 101.03 (63m) "Family planning demonstration project" means the medical assistance waiver program approved by the federal centers for medicare and medicaid services to provide family planning services to women of child-bearing age who are not otherwise eligible for and receiving medical assistance benefits which would include family planning services.

SECTION 2. HFS 102.01 (5) (e) and (6) are amended to read:

HFS 102.01 (5) (e) When a ~~child~~person is under the age of 18 and is a parent or is pregnant, but is not married and is 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~~person. When a person applies solely for benefits under the family planning demonstration project, the department shall determine the eligibility of the person without regard to the person's parent or parents.

(6) PROVIDING CORRECT AND TRUTHFUL INFORMATION. The applicant, recipient, or person described in sub. (7) who is acting on behalf of the applicant or recipient is responsible for providing to the agency, the department or the department's 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, except that changes in household income will not have to be reported for persons receiving benefits under the family planning demonstration project.

SECTION 3. HFS 102.04 (3) (c) is amended to read:

HFS 102.04 (3) (c) Within 12 months after the date initial eligibility is determined for AFDC-related persons and persons eligible for BadgerCare or for the family planning demonstration project;

SECTION 4. HFS 103.01 (1) (a) is amended to read:

HFS 103.01 Introduction. (1) PERSONS ELIGIBLE. (a) Eligibility for medical assistance (MA) shall be determined pursuant to ss. 49.45 (24r), 49.455, 49.46 (1), 49.47 (4), 49.472 and 49.665, Stats., and this chapter, except that MA shall be provided without eligibility determination to persons receiving SSI or those persons who would currently be eligible under the AFDC program that was in place on July 16, 1996 in this state pursuant to s. 49.19, Stats.

SECTION 5. HFS 103.03 (1) (title) and (a) are amended to read:

HFS 103.03 (1) AFDC-RELATEDNESS, SSI-RELATEDNESS, ~~OR~~ BADGERCARE ELIGIBILITY OR FAMILY PLANNING WAIVER. (a) *Requirement.* To be non-financially eligible for MA, an applicant shall be AFDC-related, SSI-related or meet the non-financial requirements under par. (f) for BadgerCare, or par. (i) for the family planning demonstration project for as long as the waiver is in effect.

SECTION 6. HFS 103.03 (1) (i) is created to read:

HFS 103.03 (1) (i) *Family planning demonstration project non-financial eligibility.* To be non-financially eligible for the family planning demonstration project, a person shall:

1. Be a woman at least 15 years old and no older than 44 years.

2. Not be receiving Medicaid, unless the person is eligible for medical assistance under s. 49.46 (1) (a) 15. or 49.468, Stats.

3. Meet the other non-financial criteria in subs. (2) through (7).

4. Cooperate with providing information to assist in pursuing third parties who may be liable to pay for services covered under medical assistance as required under 42 CFR 433.147, except for persons receiving medical assistance benefits only under the family planning demonstration project.

SECTION 7. HFS 103.03 (8) and (9) are amended to read:

HFS 103.03 (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 49.77, 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, or is eligible for services under the family planning demonstration project under s. 49.45 (24r), Stats.

(9) NOT A STRIKER. A person on strike is not eligible. When the striker is a caretaker relative, all members of the MA group who are 18 years of age or older shall be ineligible except that if the member of the MA group who is on strike is medically verified as pregnant or, if the MA group includes a medically verified pregnant woman, the pregnant woman continues to be eligible during her pregnancy and through the month in which the 60th day following the end of pregnancy falls or is eligible for services under the family planning demonstration project under s. 49.45 (24r), Stats. 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 employees 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 employees.

SECTION 8. HFS 103.04 (10) and (11) are created to read:

HFS 103.04 (10) FAMILY PLANNING DEMONSTRATION PROJECT. (a) A person that meets the requirements of s. HFS 103.03 (1) (i) and (2) to (7) and the income limits of par. (b) or (c) or the criteria under par. (d) is eligible for the family planning services demonstration project.

(b) The income for a family planning demonstration project fiscal test group may be no greater than 185% of the poverty line for a family the size of the group.

(c) The income for a family planning demonstration project family fiscal unit may be no greater than an amount based on 185% of the poverty line for a family the size of the family fiscal unit, or a prorated amount based on criteria in sub. (11) (e).

(d) Women who lose eligibility for medical assistance within 90 days of the end of their pregnancy are financially eligible for the family planning demonstration project for the 12 calendar months following the end of their eligibility for pregnancy-related medical assistance regardless of their income.

(11) FAMILY PLANNING DEMONSTRATION PROJECT BUDGETING PROCEDURES. (a) *Initial and subsequent determination.* To determine whether a person meets the income limits in sub. (10), the net income of the members of the fiscal test group described in par. (b) will first be compared to the income limit in sub. (10) (b). If the net income of the fiscal test group exceeds the limit, the net income of the family fiscal unit described in par. (c) will also be compared to the income limit in sub. (10) (c).

(b) *Family planning demonstration project fiscal test group.* Except for SSI recipients, the following shall be included in the fiscal test group:

1. The applicant.

2. The applicant's spouse who resides in the home with the applicant.

3. Natural or adoptive children under age 18 of the applicant who reside in the home with the applicant.

4. A fetus the applicant or a child specified in subd. 3. has been medically verified as carrying.

(c) *Family planning demonstration project family fiscal unit.* The family fiscal unit shall include all of the following:

1. The applicant.

2. The applicant's spouse who is residing in the home with the applicant, unless the spouse is an SSI recipient.

3. A fetus the applicant has been medically verified as carrying.

(d) *Inclusion of net income.* After applying the income disregards and deductions found in s. HFS 103.07 (2) and (3) to the gross income, the net income of anyone included in the fiscal test group in par. (b) or in the family fiscal unit in par. (c) will be included when determining the financial eligibility of the applicant after applying the income disregards and deductions found in s. HFS 103.07 (2) and (3) to the gross income.

(e) *Family fiscal unit budgeting procedures.* 1. The amount of the applicant's net income determined in par. (d) counted in determining financial eligibility for the family planning demonstration project shall be divided by the number of persons living in the home for whom the applicant is financially responsible in accordance with s. 49.90 (1m), Stats., including the applicant.

2. The amount of net income determined in par. (d) of an applicant's spouse, who is in the family fiscal unit, counted in determining the financial eligibility of the applicant shall be divided by the number of persons living in the home for whom the spouse is financially responsible in accordance with s. 49.90 (1m), Stats., including the spouse.

3. Financial eligibility is determined using the following process:

a. Start with the amount that is 185% of the poverty line for a family the size of the applicant's family fiscal unit.

b. Multiply the amount in subd. 3. a. by the total of the number of fetuses in par. (c) 3. plus one.

c. Divide the amount in subd. 3. b. by the total number in the family fiscal unit. The result is the income limit for this family fiscal unit.

d. The total of the income amounts derived from subds. 1. and 2. shall be less than or equal to the income limit from subd. 3. c., for the applicant to be considered to have met the income limit in sub. (10) (c).

SECTION 9. HFS 103.08 (1) is amended to read:

HFS 103.08 Beginning of eligibility. (1) DATE. Except as provided in subs. (2) to ~~(5)~~(6), 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~~for any of the 3 previous months may occur even though the applicant is found ineligible in the month of application.

SECTION 10. HFS 103.08 (6) is created to read:

HFS 103.08 (6) FAMILY PLANNING DEMONSTRATION PROJECT. Eligibility for the family planning demonstration project shall begin on the first day of the month in which all eligibility requirements are met, but no earlier than the first day of the month of application.

SECTION 11. HFS 103.089 is created to read:

HFS 103.089 Conditions for continuation of eligibility under family planning demonstration project. (1) Changes in income or in the size of the fiscal test group or family fiscal unit that result in the income exceeding the project's income limit shall not affect the recipient's eligibility for the remainder of the 12-month certification period.

(2) Notwithstanding sub. (1), eligibility for the family planning demonstration project shall terminate when the recipient no longer meets the non-financial eligibility requirements under s. HFS 103.03 (1) (i).

(3) When eligibility is reviewed at the end of the 12-month certification period, the recipient shall meet the requirements under s. HFS 103.04 (10) for eligibility under the family planning demonstration project to continue.

SECTION 12. HFS 103.11 (title) and (1) (intro) are amended to read:

HFS 103.11 Presumptive eligibility ~~for pregnant women~~. (1) REQUIREMENTS. Pregnant women may be determined presumptively eligible for MA on the basis of verification of pregnancy and preliminary information about family income. Women also may be determined presumptively eligible under the family planning demonstration project. That determination shall be made by providers designated by the department who are qualified in accordance with this section. A provider qualified to make determinations of presumptive eligibility for pregnant women shall meet the following requirements:

SECTION 13. HFS 103.11 (3) is created to read:

HFS 103.11 (3) PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING DEMONSTRATION PROJECT. (a) Women may become eligible for the family planning demonstration project initially through presumptive eligibility determined by a certified MA provider who the department determines to be qualified and is any of the following:

1. A service provider under sub. (1) (b).

2. A family planning clinic or agency under s. HFS 105.36.

(b) A qualified provider shall determine presumptive eligibility on the basis of preliminary information that:

1. The woman is 15 years of age or older and under age 45.

2. The woman is a Wisconsin resident.

3. The woman is a citizen of the U.S.

4. The woman is not a recipient of presumptive eligibility under this subsection during the 12 months preceding the date of application.

5. The woman is not otherwise receiving MA.

6. The woman's family income meets the applicable income limits.

(c) A woman may qualify for no more than one period of presumptive eligibility under this subsection per 12-month period. The presumptive eligibility period will extend from the date a qualified provider determines presumptive eligibility to the last day of the second calendar month following the date the provider makes the determination.

(d) The provider shall inform the woman, in writing, of the determination of presumptive eligibility and that if she fails to file an application for MA eligibility with the agency in the county in which the woman resides by the last day of the second calendar month following the month of the presumptive eligibility determination, her presumptive eligibility will end no later than that day.

(e) In the event that the provider determines that a woman is not presumptively eligible, the provider shall inform her that she may file an application for MA eligibility at the agency in the county in which she resides.

SECTION 14. HFS 104.02 (7) is amended to read:

HFS 104.02 (7) FINANCIAL RESPONSIBILITY OF SPOUSE OR RESPONSIBLE RELATIVE. Within the limitations provided by s. 49.90, Stats., and this chapter, the spouse of an applicant of any age or the parent of an applicant under 18 years of age, except for the parent of an applicant under 18 years of age when that applicant is eligible for services under the family planning demonstration project, shall be charged with the cost of medical services before MA payments shall be made. However, eligibility may not be withheld, delayed or denied because a responsible relative fails or refuses to accept financial responsibility. When the 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 agency notifies the relative of the obligation to do so, the agency shall notify the district attorney in order to commence legal action against that relative.

SECTION 15. HFS 107.21 (4) is created to read:

HFS 107.21 (4) SERVICES UNDER THE FAMILY PLANNING DEMONSTRATION PROJECT. (a) Except as provided in par. (b), the services identified in this section are covered for

persons eligible for the family planning demonstration project under s. 49.45 (24r), Stats., to the same extent and subject to the same conditions and limitations as specified in this section.

(b) A laboratory and other other diagnostic service under s. HFS 107.21 (1) (c) is covered for persons eligible for the family planning demonstration project under s. 49.45 (24r), Stats., only if the primary purpose of the office visit is contraceptive management.

(c) The following services not otherwise identified under this section are covered for persons eligible for the family planning demonstration project under s. 49.45 (24r), Stats.:

1. Specialized motor vehicle services, as described in and subject to the restrictions under s. HFS 107.23 (1) (c).

2. Common carrier transportation services, as described in and subject to the restrictions under s. HFS 107.23 (1) (d).

3. Other than for the treatment of acquired immune deficiency syndrome, contraceptives and prescription drugs for sexually-transmitted diseases under s. HFS 107.10 (1).

4. The intramuscular injection of an antibiotic.

Note: Recipients of benefits under both the family planning demonstration project and the tuberculosis services benefit may receive medications, procedures, services and supplies relating to tuberculosis treatment.

The rules contained in this order shall take effect as emergency rules upon publication in the official state newspaper as provided in s. 227.24 (1) (c), Stats.

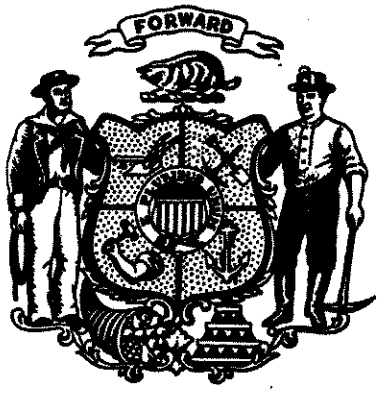
Wisconsin Department of Health
and Family Services

Dated: January 30, 2003

By: _____
Helene Nelson
Secretary

SEAL:

END



END

EMERGENCY RULE
HFS 109

RELATING TO SENIORCARE

JCRAR HEARING
March 27, 2003
10 a.m. – 411 South

State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

February 24, 2003

The Honorable Joseph Leibham, Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 409 South, State Capitol
P.O. Box 7882
Madison, Wisconsin 53707-7882

Dear Senator Leibham:

The Department of Health and Family Services has an emergency rulemaking order in effect that will expire before it is replaced by permanent rules unless the effective period of the emergency order is extended. Pursuant to s. 227.24 (2), Stats., I ask the Joint Committee to extend the effective period of the emergency order by 60 days as indicated below. The emergency rules are as follows:

Chapter HFS 109, Seniorcare. The emergency rulemaking order creating rules was published and effective on September 1st, 2002, and will expire on **March 29th**, unless extended. The Department's rulemaking order enables the Department to administer the SeniorCare program.

The Department submitted replacement final proposed permanent rules to the presiding officers on February 4, 2003. The Department does not expect the permanent rules to become effective until May 1st at the earliest. Therefore, I request an extension of the effective period of the emergency rules by **60 days**, through May 28th, 2003. If the effective period of the emergency rules is not extended, in the interim, the Department will not have the authority to administer ch. HFS 109.

A copy of the emergency rulemaking order is attached to this letter. If you have any questions about the rules, you may contact Jim Vavra, Director of Health Care Benefits in the Division of Health Care Financing at 261-7838.

Sincerely,

Helene Nelson
Secretary

Attachment

cc Representative Grothman
Gary Radloff

SENATOR JOSEPH LEIBHAM
CO-CHAIR

P.O. BOX 7882
MADISON, WI 53707-7882
(608) 266-2056

REPRESENTATIVE GLENN GROTHMAN
CO-CHAIR

P.O. BOX 8952
MADISON, WI 53708-8952
(608) 264-8486

March 28, 2003

Helene Nelson, Secretary
Department of Health and Family Services
1 West Wilson Street, Ste. 650
Madison, WI 53702

Dear Secretary Nelson:

The Joint Committee for the Review of Administrative Rules met in Executive Session on March 27, 2003 and adopted the following motion:

Emergency Rule HFS 109 **Relating to Seniorcare.**
Moved by Representative Grothman, seconded by Representative Gunderson that, pursuant to s. 227.24(2)(a), Stats., the Joint Committee for Review of Administrative Rules extends HFS 109 at the request of Department of Health and Family Services by 60 days. Motion Carried 10 Ayes, 0 Noes, 2 Absent.

Pursuant to s. 227.24(2)(c) Stats, we are notifying the Secretary of State and the Revisor of Statutes of the Committee's action through copies of this letter.

Sincerely,

Joseph R. Leibham
Senator Joseph Leibham
Senate Co-Chair

Representative Glenn Grothman
Assembly Co-Chair

JKL:GSG:pv

cc: Secretary of State Doug LaFollette
Revisor of Statutes Gary Poulson

SENATOR JOSEPH LEIBHAM
CO-CHAIR

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JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES

March 28, 2003

The Honorable Alan Lasee
Senate President
State Capitol Building, Room 220 South
Madison, WI 53702

The Honorable John Gard
Assembly Speaker
State Capitol Building, Room 211 West
Madison, WI 53702

Dear President Lasee and Speaker Gard:

The Joint Committee for the Review of Administrative Rules met in Executive Session on March 27, 2003 and adopted the following motions:

Emergency Rule DOC 316 **Relating to Medical, Dental and Nursing Co-payment Charge.**
Moved by Representative Grothman, seconded by Representative Gunderson that, pursuant to s. 227.24(2)(a), Stats., the Joint Committee for Review of Administrative Rules extends DOC 316 at the request of the Department of Corrections by 60 days.
Motion Carried 10 Ayes, 0 Noes.

Emergency Rule HFS 109 **Relating to SeniorCare.**
Moved by Representative Grothman, seconded by Representative Gunderson that, pursuant to s. 227.24(2)(a), Stats., the Joint Committee for Review of Administrative Rules extends HFS 109 at the request of the Department of Health and Family Services by 60 days.
Motion Carried 10 Ayes, 0 Noes.

Emergency Rule NR 10 and 15 Rules relating to the Control and Management of Chronic Wasting Disease.
Moved by Representative Scott Gunderson, seconded by Senator Welch that, the Joint Committee for Review of Administrative Rules (JCRAR) requests that Department of Natural Resources (DNR):

1. Extend, pursuant to s. 227.24 (2) (a), Stats., the effective period of emergency rules NR 10 and 15 for a period of 14 days through April 10, 2003.

2. Requests that the Department of Natural Resources amend emergency rules NR 10 and 15 to provide for all of the following:

    a. A person, north of state highway 10, may not hunt with the aid of more than two gallons of bait within any 40-acre site.

    b. A person, in order to draw deer or elk for viewing purposes on sites outside of the CWD management zone, may place no more than two gallons of feed within 100 yards of a residence owned or leased by that person, except that feed may not be placed within 100 yards of any highway that is posted with a speed limit of at least 45 miles per hour.

Motion Carried 10 Ayes, 0 Noes.

Pursuant to s. 227.24(2)(c), stats., as treated by 1997 Wisconsin Act 185, please forward a copy of this notice to the chairperson of the standing committee in your respective house most likely to have jurisdiction over the Clearinghouse Rule corresponding to this emergency rule.

Sincerely,

Senator Joseph K. Leibham
Senate Co-Chair

Representative Glenn Grothman
Assembly Co-Chair

JKL:GSG:pv

cc: Secretary of State Doug LaFollette
Revisor of Statutes Gary Poulson

ORDER OF THE
DEPARTMENT OF HEALTH AND FAMILY SERVICES
CREATING RULES

FINDING OF EMERGENCY

The Department of Health and Family Services finds that an emergency exists and that the rules are necessary for the immediate preservation of the public peace, health, safety or welfare. The facts constituting the emergency are as follows:

The high cost of prescription drugs in Wisconsin and nationwide are especially burdensome on the elderly, many of whom live on a fixed income. Through 2001 Act 16, Wisconsin has addressed the problem those increasingly high costs pose to the elderly by creating section 49.688 of the statutes. Section 49.688 directs the Department to develop and administer the program of prescription drug benefits for the elderly that has come to be known as "SeniorCare." The statute also directs the Department to develop administrative rules for implementing SeniorCare, which the Department has done by creating a new chapter of administrative rules, HFS 109. The rules address a variety of issues associated with operating the program in accordance with section 49.688, Stats., including specifying:

- what prescription drugs are covered;
- who is eligible for benefits and services;
- how the Department determines household income for the program's eligibility determination;
- how the Department monitors compliance by pharmacists and pharmacies; and
- mechanisms for preventing fraud and abuse.

The Department drafted these rules to parallel the prescription drug provisions of the existing Medicaid rules in chapters HFS 101 to 108. The Department developed the program's administrative elements in consultation with an advisory committee composed of representatives of physicians, counties, seniors and pharmacies.

While the Department is currently in the process of promulgating ch. HFS 109 as permanent rules, s. 49.688 (5) (a) and (7) (a), Stats., mandate the initiation of some SeniorCare program elements beginning on September 1, 2002. To meet this deadline, the Department is issuing ch. HFS 109 as emergency rules to preserve the public welfare.

ORDER

Pursuant to the authority vested in the Department of Health and Family Services by ss. 49.688, 227.11 (2) (a) and 227.24 (1), Stats., the Department of Health and Family Services hereby creates rules interpreting s. 49.688, Stats.

SECTION 1. HFS 109 is created to read:

Chapter HFS 109

SENIOR CARE

Subchapter I - General Provisions

Subchapter II - Eligibility for SeniorCare Benefits and Services

Subchapter III - Drug Benefits

Subchapter IV - Program Integrity

Subchapter V – Provider Rights and Responsibilities

Subchapter VI – Participant Rights and Responsibilities

Subchapter VII - Program Administration

Subchapter I - General Provisions

HFS 109.01 Authority and purpose. This chapter is promulgated under the authority of ss. 49.688 and 227.11 (2), Stats., to implement a program called SeniorCare that is designed to provide prescription drug assistance for Wisconsin residents aged 65 years or older and who meet the program's eligibility criteria. The chapter does all of the following:

(1) Establishes the application process for SeniorCare.

(2) Describes how the department will determine eligibility for SeniorCare benefits and services.

(3) Identifies SeniorCare benefits, services and fees.

(4) Establishes requirements of SeniorCare participants and providers.

(5) Identifies the applicability of other department rules.

HFS 109.02 Applicability. This chapter applies to all of the following:

(1) The department.

(2) All persons applying to receive SeniorCare benefits and services.

(3) All persons found eligible to receive SeniorCare benefits and services.

(4) All persons prescribing or providing drugs to SeniorCare participants.

(5) All drug manufacturers who sell drugs for prescribed use in Wisconsin by SeniorCare participants.

HFS 109.03 Definitions. Unless otherwise defined in this chapter, the definitions in s. HFS 101.03 apply to this chapter. In addition, in this chapter:

(1) "Deductible benefits and services" means both of the following:

(a) The prescription drugs which may be purchased by a SeniorCare participant with income over 160% of the poverty line for amounts no greater than the program payment rate.

(b) The department's tracking of prescription drug purchases by a SeniorCare participant with income over 160% of the poverty line so SeniorCare providers know when the participant may receive the SeniorCare prescription benefit.

(2) "Department" means the department of health and family services, or its agent.

(3) "Fiscal test group" means the person or persons in a household whose income and need is included in determining which SeniorCare benefits or services an applicant may receive.

(4) "Generic name" has the meaning given in s. 450.12 (1) (b), Stats.

(5) "Innovator multiple-source drug" means a multiple source drug that was originally marketed under an original new drug application approved by the U.S. food and drug administration.

(6) "Lock-in provider" means a single, SeniorCare-certified provider, selected by the participant or designated by the department in the event the participant is unwilling or unable to identify a provider, who is responsible for either personally providing all non-emergency care received by the participant under the MA program, or referring the participant to a specific provider for such needed non-emergency care.

(7) "Participant" means a person who has applied for SeniorCare and meets the eligibility criteria under s. HFS 109.11 (1) and may receive benefits and services during the benefit period under s. HFS 109.14.

(8) "Pharmacist" has the meaning given in s. 450.01 (15), Stats.

(9) "Prescription benefit" means the prescription drugs that may be purchased with a $5 or $15 payment by a SeniorCare participant with low income or who has spent at least $500 on the purchase of prescription drugs during the current benefit period.

(10) "Prescription drug" has the meaning given in s. 450.01 (20), Stats., that is included in the drugs specified under s. 49.46 (2) (b) 6. h., Stats., and s. HFS 109.31 and is manufactured by a drug manufacturer that enters into a rebate agreement in force under s. HFS 109.71.

(11) "Prescription order" has the meaning given in s. 450.01 (21), Stats.

(12) "Program payment rate" means the rate of payment made for the identical drug specified under s. 49.46 (2) (b) 6. h., Stats., plus 5%, plus a dispensing fee that is equal to the dispensing fee permitted to be charged for prescription drugs for which coverage is provided under s. 49.46 (2) (b) 6. h., Stats.

(13) "Retail price" means the provider's charge for providing the same service to private paying customers.

(14) "SeniorCare" means the program of prescription drug assistance for eligible elderly persons under s. 49.688, Stats.

(15) "SeniorCare provider" means a Medicaid certified pharmacist, pharmacy or dispensing physician.

(16) "Spenddown" means the amount of money a SeniorCare participant must spend on prescription drugs before the participant becomes eligible for SeniorCare deductible and copayment benefits and services.

(17) "Spenddown services" means the department's monitoring of participant prescription drug purchases to determine when the participant's SeniorCare fiscal test group's purchases have equaled the difference between the fiscal test group's annual income and 240% of the poverty line for a family the size of the fiscal test group.

(18) "U.S. national" means any of the following:

(a) A person born in one of the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam, the U.S. Virgin Islands (on or after January 17, 1917), America Samoa, Swain's Island or the Northern Mariana Islands.

(b) A person born outside of the United States to at least one U.S. citizen parent.

(c) A naturalized U.S. citizen.

Subchapter II - Eligibility for SeniorCare Benefits and Services

HFS 109.11 Application and determining eligibility. (1) CONDITIONS FOR ELIGIBILITY. A person who meets all of the following requirements shall be eligible for SeniorCare and shall be issued a prescription drug card for use in purchasing prescription drugs:

(a) The person is a resident of the state of Wisconsin as defined in s. 27.01 (10) (a), Stats. The temporary absence of a resident from the state shall not be grounds for denying or terminating SeniorCare eligibility unless another state has determined the person is a resident in the other state for purposes of medical assistance.

(b) The person is at least 65 years of age.

(c) The person is not a recipient of medical assistance, or as a recipient, does not receive prescription drug coverage. Persons who only receive Medicare buy-in benefits under s. 49.468, Stats., 42 USC 1396a(a)(10)(E), or 42 USC 1396u-3, are not considered a medical assistance recipient under this chapter.

(d) The person pays the program enrollment fee specified in s. HFS 109.16.

(e) 1. Except as provided in subd. 2., the person requesting SeniorCare benefits has a social security number and furnishes the number to the department.

2. a. If an applicant does not have a social security number, the applicant or a person acting on behalf of the applicant shall apply to the federal social security administration for a number. The department may not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's social security number.

b. If the applicant or a person acting on behalf of an applicant refuses to furnish a number or apply for a number, the applicant shall be ineligible for SeniorCare.

(f) The person is a U.S. national or an alien legally residing in the U.S. and whose status qualifies them for medical assistance under 8 USC 1611 through 8 USC 1613, except that an alien whose status would qualify them only for emergency medical assistance benefits under 42 USC 1396b(v)(3) is not eligible for SeniorCare.

(g) The applicant, participant, or person described in sub. (2) (d) who is acting on behalf of the applicant or participant provides correct and truthful information as specified under sub. (2) (c).

(h) The person is not an inmate of a public institution as defined in 42 CFR 435.1009.

(2) APPLICATION FOR SENIORCARE. Application for SeniorCare shall be made pursuant to s. 49.688, Stats, and this chapter. Applications shall be made and reviewed in accordance with the following provisions:

(a) *Right to apply*. Any person may apply to the department for SeniorCare on a form prescribed by the department.

Note: Application forms for SeniorCare are widely available through various local agencies. A copy of the application form is also available at the Department's Internet web site at: http://www.dhfs.state.wi.us.

(b) *Access to information*. The department shall provide information, in writing or orally, as appropriate, to persons inquiring about or applying for SeniorCare: coverage; conditions of eligibility; scope of the program and related services available; and applicant and participant rights and responsibilities.

(c) *Providing correct and truthful information*. The applicant, participant, or person described in par. (d) acting on behalf of the applicant or participant shall provide to the department full, correct and truthful information necessary for eligibility determination, redetermination, or for processing SeniorCare prescription claims, including health insurance policies or other health care plans and claims or causes of action against other parties on the part of the applicant or participant. Changes in circumstances that may affect eligibility shall be reported to the department within 10 calendar days of the change.

(d) *Signing the application*. The applicant or the legal guardian, authorized representative or, where the applicant is incompetent or incapacitated, someone acting responsibly for the applicant, shall sign each application. Two witnesses shall also sign the application when the applicant signs the application with a mark.

(3) REFUSAL TO PROVIDE INFORMATION. If an applicant refuses or fails to provide information necessary for the determination of SeniorCare eligibility, the department shall deny eligibility to the applicant or participant and the spouse of the applicant or participant.

(4) DEPARTMENT VERIFICATION OF INFORMATION. (a) The department shall verify data elements the department deems appropriate under any of the following circumstances:

1. The applicant has been convicted of public assistance-related fraud.

2. The applicant is repaying aid determined to be previously owed by the applicant pursuant to an agreement with the district attorney's office.

3. The applicant is known to have provided erroneous information on a previous SeniorCare or medical assistance application that resulted in an incorrect issuance of medical assistance or SeniorCare assistance.

(b) The department may verify the following information about the applicant, participant or an ineligible spouse who is in the fiscal test group:

1. Income.

2. Health insurance coverage as defined in s. HFS 101.03 (69m) and other plans that provide prescription benefits.

3. Age.

4. Residence.

5. Social security number.

6. Citizenship or alien status.

(c) The department shall deny or terminate an applicant's or participant's SeniorCare eligibility if the applicant or participant is able to produce required verifications but refuses or fails to do so. If the applicant or participant cannot produce verifications, or requires assistance to do so, the department may not deny eligibility to the applicant or participant, but shall proceed immediately to verify the data elements in par. (b).

(5) ELIGIBILITY DETERMINATION PROCESS. (a) *Decision date.* 1. Except as provided in subd. 2., the department shall determine the applicant's eligibility for SeniorCare as soon as possible for applications the department receives on or after September 1, 2002, but not later than 30 days from the date the department receives a signed application that contains, at a minimum, the name and address of the applicant.

2. If a delay in processing the application occurs because of a delay in securing necessary information, the department 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 under s. HFS 109.17 to appeal the delay.

(b) *Notice of Decision.* 1. Except as provided under subd. 2., the department shall send timely and adequate notice to an applicant or participant to indicate that the applicant's or participant's participation in SeniorCare has been authorized, reduced, denied or terminated. In this paragraph, "timely" means in accordance with 42 CFR 431.211, and "adequate notice" means a written notice that contains a statement of the action taken, the reasons for and specific rules supporting the action, and an explanation of the individual's right to request a hearing under s. HFS 109.17, and the circumstances under which the benefits and services under s. HFS 109.13 will be continued if a hearing is requested.

2. When the department determines a prescription drug billing must be corrected due to an incorrect billing, and that correction results in a change in the benefits and services received under s. HFS 109.13, the timely notice requirements under subd. 1. do not apply.

(c) *Withdrawal of application.* Except as provided in par. (d), an applicant may withdraw a SeniorCare application and request a refund of the enrollment fee in s. HFS 109.16 at any time before the department has made an eligibility determination.

(d) *Withdrawal deadline.* An applicant who is notified that he or she is eligible for SeniorCare and who has not received any SeniorCare prescription drug benefit or service described in s. HFS 109.13 may request to withdraw the application and receive a refund of the enrollment fee in s. HFS 109.16 up to the latter of the following:

1. Ten days following the issuance of the eligibility notice.

2. Thirty days from the date the application was filed.

(6) REVIEW OF ELIGIBILITY. The department shall redetermine a SeniorCare participant's eligibility any time one of the following conditions is met:

(a) Promptly after the department learns of a change in the person's circumstances that may affect eligibility or indicates the need for redetermination.

(b) Within 12 months after the date the person has been determined to be eligible as part of the annual review conducted under s. HFS 109.14 (7).

(c) At any time the department has a reasonable basis for believing that a participant is no longer eligible for SeniorCare.

HFS 109.12 Calculation of eligible benefits and services. Persons the department determines to be eligible for SeniorCare benefits and services under s. HFS 109.11 may be subject to program deductible and spenddown amounts that participants must pay before the participant may receive the full SeniorCare benefits and services for the remainder of a benefit period. Whether and to what extent the deductibles and spenddown amounts under s. HFS 109.13 apply to a given participant depends on the annual income of the participant's fiscal test group. The department shall calculate income for the participant's fiscal test group as follows:

(1) SENIORCARE FISCAL TEST GROUP. The SeniorCare fiscal test group shall consist solely of the applicant unless the applicant is residing with a spouse. If the applicant is residing with a spouse, the SeniorCare fiscal test group shall consist of the applicant and the applicant's spouse, unless the spouse is an SSI recipient or the spouses are living together in a nursing home.

(2) ANNUAL INCOME. The department shall calculate annual income for SeniorCare applicants as follows:

(a) Income shall be based on a prospective estimate of annual budgetable income under par. (c) for all persons in the SeniorCare fiscal test group.

(b) The annual period used as the basis for the estimate shall be the 12 calendar months beginning with the month in which the SeniorCare application was filed.

(c) Budgetable income shall consist of gross earned and unearned income with the following exceptions:

1. Self-employment income shall be calculated by deducting only estimated business expenses, losses, and depreciation from gross self-employment income.

2. Income from sources exempted under federal law from consideration for Medicaid eligibility will also be exempt for SeniorCare.

HFS 109.13 SeniorCare benefits and services. (1) CONDITIONS FOR RECEIVING SENIORCARE BENEFITS AND SERVICES. A person who meets the eligibility requirements under s. HFS 109.11 (1) may receive SeniorCare benefits or services, subject to the conditions under this section. SeniorCare benefits and services are only available for prescription drugs prescribed for the eligible person and dispensed with a date of service during the eligible person's benefit period.

(2) PRESCRIPTION BENEFIT. (a) *Income category applicability.* A person may receive the prescription benefit in par. (b) under any of the following conditions:

1. The person is a member of a fiscal test group with an annual income less than or equal to 160% of the poverty line for a family the size of the fiscal test group.

2. The person is a member of a fiscal test group with an annual income greater than 160% but not in excess of 240% of the poverty line for a family the size of the fiscal test group and has met the deductible as described in sub. (3) (d) during the current benefit period.

3. The person is a member of a fiscal test group with an annual income greater than 240% of the poverty line for a family the size of the fiscal test group and has met both of the following thresholds during the current benefit period, in the following order:

a. The spenddown as described in sub. (4) (c).

b. The deductible as described in sub. (3) (d).

(b) *Copayment.* Except as provided under sub. (3) (e), a person receiving the SeniorCare prescription benefit may purchase prescription drugs from participating SeniorCare providers for one of the following copayment amounts:

1. A copayment of $5 for each prescription drug that bears only a generic name.

2. A copayment of $15 for each prescription drug that does not bear only a generic name.

(c) *Exclusion.* If a drug is covered by a third party and the participant makes a copayment to the SeniorCare provider, the department is not responsible for refunding the copayment amount to the participant.

(3) DEDUCTIBLE BENEFIT AND SERVICES. (a) *Income category applicability.* A person may receive the SeniorCare benefit and services under par. (b) under any of the following conditions:

1. The person is a member of a fiscal test group with an annual income greater than 160%, but not in excess of 240% of the poverty line for a family the size of the fiscal test group.

2. The person is a member of a fiscal test group with an annual income greater than 240% of the federal poverty line for a family the size of the fiscal test group, but only for the remainder of the benefit period after he or she has met the spenddown as described in sub. (4) (c).

(b) *Benefit and services.* 1. Except as provided under sub. (4) (d), a person receiving the SeniorCare deductible benefit and services may purchase prescription drugs from participating SeniorCare providers at the program payment rate.

2. The department shall maintain a record of the prescription drug purchases of each person receiving the SeniorCare deductible services and shall inform participating SeniorCare providers when the person receiving the SeniorCare deductible benefits and services has met the deductible within the benefit period as described in par. (d).

(c) *Amount.* The amount of the SeniorCare deductible is $500.

(d) *Meeting the deductible.* The deductible is considered met and the person shall receive the prescription benefit under sub. (2) (b) when, under the following conditions, the person has spent $500 in purchasing prescription drugs:

1. Only purchases of prescription drugs prescribed for the eligible individual count toward meeting the deductible.

2. Each spouse has a $500 deductible. When both persons in a 2-person fiscal test group are eligible for SeniorCare, each person's purchases of prescription drugs shall only be counted toward meeting the deductible of the person for whom the drugs are prescribed.

3. Only prescription drugs dispensed with a date of service during the current benefit period described in s. HFS 109.14 may count toward meeting the deductible.

4. If a person has other available coverage from any third party insurer legally liable to contribute in whole or in part to the cost of prescription drugs provided to a SeniorCare participant, including coverage by a county relief program under ch. 49, Stats., only costs for prescription drugs for the person that are not paid under the person's other available coverage will count toward meeting the deductible.

5. Only prescription drugs that meet the requirements of s. HFS 109.31 may be applied toward meeting the deductible.

6. Only claims submitted by a SeniorCare provider shall be considered in determining whether or not the participant has met the deductible.

(e) *Carryover of deductible.* When the cost of a prescription applied towards meeting the deductible under par. (d) exceeds the remaining deductible amount, the excess prescription costs shall be applied to the prescription benefit. The participant shall not be required to pay the copayment under sub. (2) (b) for that prescription.

(4) SPENDDOWN SERVICES. (a) *Income category applicability.* 1. A person may receive the SeniorCare spenddown services under this subsection when he or she is in a fiscal test group with an annual income that exceeds 240% of the poverty line for a family the size of the fiscal test group.

2. The department shall maintain an accounting of the prescription drug purchases of each person receiving the SeniorCare spenddown services and shall inform participating SeniorCare providers when he or she has met the spenddown within the benefit period as described in par. (c).

(b) *Amount.* The amount of a person's SeniorCare spenddown is the difference between the SeniorCare fiscal test group's annual income and 240% of the poverty line for a family the size of the fiscal test group.

(c) *Meeting a spenddown.* A SeniorCare spenddown shall be met and the person's subsequent prescription purchases shall count toward meeting the deductible under sub. (3) (c) and (d) when the member or members of the fiscal test group, under the following conditions, have spent the amount of the spenddown in purchasing prescription drugs at the retail price:

1. When only one person is an eligible member of the SeniorCare fiscal test group in a calendar month, only purchases of prescription drugs prescribed for that person are counted toward meeting the spenddown in that calendar month.

2. When 2 spouses are both eligible members of the same SeniorCare fiscal test group in a calendar month, purchases of prescription drugs prescribed for either person are counted toward meeting the spenddown in that month.

3. Only prescription drugs dispensed with a date of service during the benefit period described in s. HFS 109.14 may count toward meeting the spenddown.

4. If a person has other available coverage from any third party insurer legally liable to contribute in whole or in part to the cost of prescription drugs provided to a SeniorCare participant, including coverage by a county relief program under ch. 49, Stats., only costs for prescription drugs for the person that are not paid under the person's other available coverage will count toward meeting the spenddown.

5. Only prescription drugs that meet the requirements of s. HFS 109.31 may be applied to meeting the spenddown.

6. Only claims submitted by a SeniorCare provider will be considered in determining whether the participant has met the spenddown.

(d) *Carryover of spenddown*. When the cost of a prescription applied towards meeting the spenddown under par. (c) exceeds the remaining spenddown amount, the excess prescription costs shall be applied towards meeting the deductible under sub. (3) (d). The program payment rate shall not apply to that portion of the prescription counted for the deductible.

HFS 109.14 SeniorCare benefit period. (1) DURATION. Except as provided in subs. (3) to (5), and in ss. HFS 109.15, the benefit period for SeniorCare eligibility shall be 12 consecutive calendar months.

(2) ELIGIBILITY BEGIN DATE. Except as provided in sub. (3), a person's SeniorCare eligibility begins on the first day of the month after the date the department receives a complete application and the person meets all of the eligibility requirements.

(3) EXCEPTION FOR MEDICAID RECIPIENTS. If the department receives a complete application and determines that the person meets all other eligibility requirements prior to the date medical assistance eligibility ends, the person's SeniorCare eligibility begins the day after the person's medical assistance eligibility ends.

(4) TERMINATION OF SENIORCARE BENEFIT PERIOD. (a) Except as provided in sub. (5), the department shall terminate the SeniorCare benefit period of a SeniorCare participant who no longer meets the eligibility conditions in s. HFS 109.11.

(b) The department shall restore the SeniorCare benefit period for a person terminated ~~from~~ SeniorCare without a break in coverage if, within one calendar month of the effective termination date, he or she does both of the following:

1. Meets all of the eligibility criteria under s. HFS 109.11.

2. Notifies the department of the change in circumstances.

(5) CONTINUATION OF BENEFIT PERIOD FOR MEDICAL ASSISTANCE RECIPIENTS. The department may not terminate the benefit period of SeniorCare participants who lose eligibility solely due to receipt of medical assistance benefits. A SeniorCare participant is not eligible for any

SeniorCare benefits or services under s. HFS 109.13 for any calendar months in which he or she receives medical assistance benefits.

(6) REQUEST FOR NEW BENEFIT PERIOD. A SeniorCare participant may request a new benefit period for SeniorCare at any time. Upon receipt of a new application, the department shall determine the participant's eligibility for a new benefit period in the following manner unless the application is from the spouse of a participant and meets the conditions under 109.15:

(a) The person shall submit a new application as required under s. HFS 109.11.

(b) The department shall redetermine eligibility when the request for a new benefit period is made beginning with the date a new complete application is received.

(c) The department shall redetermine annual income for a 12-month period beginning with the date a new complete application is received.

(d) The department shall redetermine which benefits and services under s. HFS 109.13 the applicant may receive.

(e) The participant may withdraw the request for a new benefit period as allowed under s. HFS 109.11 (5).

(f) Eligibility for the new benefit period shall begin on the first day of the month after the date a new complete application is received and all the eligibility requirements are met, including payment of a new enrollment fee specified in s. HFS 109.16.

(g) Prescription drug costs that had been applied to a spenddown or deductible in a previous benefit period shall not apply to the new benefit period.

(h) Notwithstanding s. HFS 109.15, if a person eligible for SeniorCare requests a new benefit period at the same time the person's spouse applies for SeniorCare or requests a new benefit period, eligibility shall be determined under this section.

(i) The department shall terminate a participant's current benefit period once the department determines eligibility for a request for a new benefit period.

(7) ANNUAL ELIGIBILITY REVIEW. Eligibility for a new benefit period determined under s. HFS 109.11 (6) (b) shall begin on the first day of the month immediately following the end of the previous benefit period when the department receives a complete application and all the eligibility requirements are met, including payment of a new enrollment fee specified in s. HFS 109.16, prior to the end of the 12th month of the previous benefit period.

HFS 109.15 Treatment of spouses. Notwithstanding ss. HFS 109.13 and 109.14, when the spouse of a SeniorCare participant files an application or review for SeniorCare, or requests a new benefit period, and is required under s. HFS 109.12 (1) to be in the same fiscal test group as the participant, the eligibility of the spouse for benefits and services under s. HFS 109.13 and the duration of the spouse's benefit period shall be determined in the following manner, unless both the participant and the participant's spouse jointly file a request for a new benefit period under s. HFS 109.14:

(1) The department shall determine the eligibility of the spouse under s. HFS 109.11, and, if eligible for SeniorCare, determine the beginning eligibility date of the spouse's benefit period according to s. HFS 109.14.

(2) If the department under sub. (1) determines the spouse is eligible for SeniorCare the spouse's benefit period shall end on the same date as the participant's benefit period ends.

(3) If the department determines the spouse is ineligible for SeniorCare, the benefits and services that the participant spouse may receive during the participant's current benefit period shall not be affected.

(4) If the income of the spouse was not used to determine the SeniorCare benefit for the participant spouse, both of the following apply:

(a) The department shall determine the annual income for the fiscal test group for the 12-month period beginning with the month the application request for the spouse is received.

(b) The benefit and services under s. HFS 109.13 that the spouse may receive will be determined as follows:

1. 'Annual income exceeds 240% of poverty line.' a. If the annual income of the fiscal test group exceeds 240% of the poverty line for a 2-person family, the spouse may receive spenddown services under s. HFS 109.13 (4) (a) 2.

b. When determining whether the spouse meets the SeniorCare spenddown under s. HFS 109.13 (4) (c), the amount of the SeniorCare spenddown shall be prorated. The prorated amount shall be the annual spenddown amount under s. HFS 109.13 (4) (b) multiplied by the number of months of the spouse's benefit period derived from subs. (1) and (2), divided by 12. Only prescription drug costs of the spouse may count towards meeting the prorated spenddown.

c. If the spouse meets the prorated spenddown during the benefit period, the spouse may receive the deductible benefit and services under s. HFS 109.13 (3) (b). When determining whether the spouse meets the SeniorCare deductible under s. HFS 109.13 (3) (c) and (d), the amount of the SeniorCare deductible shall be prorated. The prorated deductible amount shall be $500 multiplied by the number of months of the spouse's benefit period derived from subs. (1) and (2), divided by 12.

d. If the spouse meets the prorated deductible during the benefit period, the spouse may receive the prescription benefit under 109.13 (2) (b).

2. 'Annual income between 160-240% of poverty line.' a. If the annual income of the fiscal test group is greater than 160%, but not in excess of 240% of the poverty line for a 2-person ~~fam~~ily, the spouse may receive the deductible benefit and services under s. HFS 109.13 (3) (b).

b. When determining whether the spouse meets the SeniorCare deductible under s. HFS 109.13 (3) (c) and (d), the amount of the SeniorCare deductible shall be prorated. The prorated deductible amount shall be $500 multiplied by the number of months of the spouse's benefit period derived from subs. (1) and (2), divided by 12.

c. If the spouse meets the prorated deductible during the benefit period, the spouse may receive the prescription benefit under 109.13 (2) (b).

3. 'Annual income less than 160% of poverty line.' a. If the annual income of the fiscal test group does not exceed 160% of the poverty line for a 2-person family, the spouse may receive the prescription benefit under s. HFS 109.13 (2).

(5) If the income of the spouse was used to determine the SeniorCare benefit for the participant, the department shall determine the benefit as follows:

(a) *Annual income exceeds 240% of poverty line.* 1. 'Participant has not met spenddown.' If the annual income of the fiscal test group exceeds 240% of the poverty line for a 2-person family, and the participant has not met the spenddown by the date the spouse becomes eligible for SeniorCare, the spouse may receive spenddown services under s. HFS 109.13 (4).

2. 'Participant has met spenddown.' a. If the annual income of the fiscal test group exceeds 240% of the poverty line for a 2-person family and the participant met the spenddown before the spouse becomes eligible for SeniorCare, or the participant and spouse meet the spenddown during the benefit period, the spouse may receive the deductible benefit and services under s. HFS 109.13 (3).

b. When determining whether the spouse meets the SeniorCare deductible under s. HFS 109.13 (3) (b) and (c), the amount of the SeniorCare deductible shall be prorated. The prorated deductible amount shall be $500 multiplied by the number of months of the spouse's benefit period derived from subs. (1) and (2), divided by 12.

3. If the spouse meets the prorated deductible during the benefit period, the spouse may receive the prescription benefit under 109.13 (2) (b).

(b) *Annual income between 160-240% of poverty line.* 1. If the annual income of the fiscal test group is greater than 160%, but not in excess of 240% of the poverty line for a 2-person family, the spouse may receive the deductible benefit and services under s. HFS 109.13 (3).

2. When determining whether the spouse meets the SeniorCare deductible under s. HFS 109.13 (3) (b) and (c), the amount of the SeniorCare deductible shall be prorated. The prorated deductible amount shall be $500 multiplied by the number of months of the spouse's benefit period derived from subs. (1) and (2), divided by 12.

3. If the spouse meets the prorated deductible during the benefit period, the spouse may receive the prescription benefit under 109.13 (2) (b).

(c) *Annual income less than 160% of poverty line.* If the annual income of the fiscal test group does not exceed 160% of the poverty line for a 2-person family, the spouse may receive the prescription benefit under s. HFS 109.13 (2).

HFS 109.16 Fees. For each 12-month benefit period, program participants shall pay a program enrollment fee of $20. The department shall refund the fee to applicants found to be ineligible for SeniorCare.

HFS 109.17 Applicant appeals. Any person whose application for SeniorCare is denied or is not acted upon promptly under s. HFS 109.11 (5), or who believes that the benefits or services they may receive under s. HFS 109.13 have not been properly determined, or that his or her eligibility has not been properly determined under s. HFS 109.11 (5), may file an appeal pursuant to the requirements under ch. HA 3 that apply to the medical assistance program, except for the provision under s. HA 3.05 (2) (a). The applicant shall have 45 days from the effective date of the

adverse action in which to file a request for hearing. A request for a hearing concerning the SeniorCare program may only be made in writing and only to the Division of Hearings and Appeals.

Note: A hearing request should be mailed to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI, 53707-7875. Hearing requests may be delivered in person to that office at 5005 University Ave., Room 201, Madison, WI or transmitted by facsimile machine to 608-264-9885.

Subchapter III - Drug Benefits

HFS 109.31 Covered drugs and limitations on coverage. (1) COVERED SERVICES. Drugs and drug products covered under this chapter include prescription drugs and insulin listed in the Wisconsin medical assistance drug index that are prescribed by a physician licensed under s. 448.04, Stats., by a dentist licensed under s. 447.05, Stats., by a podiatrist licensed under s. 448.04, Stats., by an optometrist licensed under ch. 449, Stats., or by a nurse prescriber under ch. N 8, or when a physician delegates prescription of drugs to a nurse practitioner or to a physician's assistant certified under s. 448.04, Stats., and the requirements under s. N 6.03 for nurse practitioners and under s. Med 8.08 for physician assistants are met. The limitations on coverage and services in this section apply to co-pay, spenddown and deductible.

(2) PRIOR AUTHORIZATION. (a) *Drugs requiring prior authorization.* The following drugs and supplies require prior authorization:

1. All schedule III and IV stimulant drugs.

2. Drugs that have been demonstrated to entail significant expense or overuse for the medical assistance program. These drugs shall be noted in the Wisconsin medical assistance drug index.

3. Drugs identified by the department that may be used to treat impotence, when proposed to be used for the treatment of a condition not related to impotence.

(b) *Request for prior authorization.* 1. In considering a prior authorization request under this chapter, the Department shall require the information required in s. HFS 107.02 (3) (d) and apply the review criteria in s. HFS 107.04 (3) (e).

2. a. If a SeniorCare provider under sub. (1) does not request and obtain prior authorization before providing a prescription drug requiring prior authorization, the department may not provide reimbursement except in an emergency.

b. Except in an emergency case as specified under subdivision par. a., the department may not cover a prescription drug or apply a participant's purchase to the deductible or spenddown if the department has not prior authorized a drug requiring prior authorization. A certified provider may not hold a recipient liable for payment for a covered service requiring prior authorization by the department unless the department denies the prior authorization request and the provider informs the recipient of the recipient's personal liability before provision of the service. If the department denies the recipient's prior authorization request, the recipient may request a fair hearing. SeniorCare providers are required to request prior authorization for all SeniorCare participants.

(3) OTHER LIMITATIONS. (a) SeniorCare providers shall limit dispensing of schedule III, IV and V drugs to the original dispensing plus 5 refills, or 6 months from the date of the original prescription, whichever comes first.

(b) SeniorCare providers shall limit dispensing of non-scheduled legend drugs and insulin to the original dispensing plus 11 refills, or 12 months from the date of the original prescription, whichever comes first.

(c) SeniorCare providers shall fill:

1. Generically-written prescriptions for drugs listed in the federal food and drug administration approved drug products publication with a generic drug included in that list.

2. Prescription orders written for brand name drugs that have a lower cost generically available drug with the lower cost drug product, unless the prescribing provider under sub. (1) writes "brand medically necessary" on the face of the prescription. The prescribing provider shall document in the patient's record the reason why the drug is medically necessary.

(d) Except as provided in par. (e), SeniorCare providers shall dispense prescription drugs in amounts not to exceed a 34-day supply.

(e) SeniorCare providers may dispense certain maintenance drugs as identified by the department, in amounts up to but not to exceed a 100-day supply, as prescribed by a physician.

(f) The only general category of over-the-counter drugs that are covered are the insulins.

(g) Only the innovator of a multiple-source drug is a covered service when the prescribing provider under sub. (1) certifies by writing the phrase "brand medically necessary" on the prescription.

(4) LOCK-IN PROGRAM. (a) *Required when program is abused.* If the department discovers that a participant is abusing the program, including the type of abuse under s. HFS 109.61 (1) and (5), the department may require the participant to designate one pharmacy as the SeniorCare lock-in provider of the participant's choice.

(b) *Selection of lock-in provider.* The department shall allow a participant to choose a lock-in provider from the department's current list of certified SeniorCare providers. The participant's choice shall become effective only with the concurrence of the designated lock-in provider.

(c) *Failure to cooperate.* If the participant fails to designate a lock-in provider within 15 days after receiving a formal request from the department, the department shall designate a lock-in provider for the participant.

(5) NON–COVERED SERVICES. In addition to possible non-coverage without prior authorization of some drugs under sub. (2) (b) 2., the following drugs are not covered under this chapter:

(a) A drug not covered under the medical assistance program under s. HFS 107.10 (4).

(b) A drug produced by a manufacturer who has not entered into a rebate agreement with the department, as required by s. 49.688, Stats.

(6) DRUG REVIEW, COUNSELING AND RECORDKEEPING. (a) In addition to complying with ch. Phar 7, a SeniorCare provider shall do all of the following:

1. Provide for a review of drug therapy before each prescription is filled or delivered to a SeniorCare participant. The review shall include screening for potential drug therapy problems including therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions and clinical abuse or misuse.

2. Offer to discuss with each SeniorCare participant, the participant's legal representative or the participant's caregiver who presents the prescription, matters which, in the exercise of the SeniorCare provider's professional judgment and consistent with state statutes and rules governing provisions of this information, the SeniorCare provider deems significant, including the following:

a. The name and description of the medication.

b. The route, dosage form, dosage, route of administration, and duration of drug therapy.

c. Specific directions and precautions for preparation, administration and use by the patient.

d. Common severe side effects or adverse effects or interactions and therapeutic contraindications that may be encountered, including how to avoid them, and the action required if they occur.

e. Techniques for self-monitoring drug therapy.

f. Proper storage.

g. Prescription refill information.

h. Action to be taken in the event of a missed dose.

3. Make a reasonable effort to obtain, record and maintain at least the following information regarding each SeniorCare participant for whom the SeniorCare provider dispenses drugs under the SeniorCare program:

a. The participant's name, address, telephone number, date of birth or age and gender.

b. The participant's medical history where significant, including any disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices.

c. The SeniorCare provider's comments related to the participant's drug therapy.

(b) Nothing in this subsection shall be construed as requiring a SeniorCare provider to provide consultation when a SeniorCare participant, the participant's legal representative or the participant's caregiver refuses the consultation.

HFS 109.32 Coverage while out-of-state. Drugs shall be covered for a SeniorCare participant only if the participant is within the United States, Canada or Mexico. Drugs provided by a person in another state who is not certified as a border status provider shall be covered only under either of the following circumstances:

(1) An emergency need for the drug arises from accident or sudden illness.

(2) When the department has granted prior authorization for provision of a non-emergency service, except that prior authorization is not required for non-emergency services provided to Wisconsin participants by border status providers certified by the Wisconsin medical assistance program.

Subchapter IV - Program Integrity

HFS 109.41 Annual report to legislature. The department shall monitor compliance with s. 49.688, Stats., and the provisions of this chapter by SeniorCare providers.

HFS 109.42 Prohibition on fraud. (1) No person may do any of the following:

(a) Knowingly and willfully make or cause to be made any false statement or representation of a material fact in any application for any SeniorCare benefit or payment.

(b) Knowingly and willfully make or cause to be made any false statement or representation of a material fact for use in determining rights to any SeniorCare benefit or payment.

(c) Have knowledge of the occurrence of any event affecting the initial or continued right to any SeniorCare benefit or payment, or the initial or continued right to any such benefit, or payment of any other individual in whose behalf he or she has applied for or is receiving such benefit or payment, or conceal or fail to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized.

(d) Having made application to receive any SeniorCare benefit or payment for the use and benefit of another and having received it, knowingly and willfully convert such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.

(2) Violators of this section shall be subject to penalties under s. 49.688 (9), Stats.

Subchapter V – Provider Rights and Responsibilities

HFS 109.51 Provider responsibility. (1) AUDIT AND PROGRAM MONITORING. (a) Providers shall comply with the audit and program monitoring conditions under s. HFS 105.01 (3) (f) 1. to 3.

(b) Nothing in this subsection shall be construed to limit the right of a provider to appeal a department recovery action brought under s. HFS 109.53 (4).

(2) CONFIDENTIALITY OF MEDICAL INFORMATION. Information about participants shall be confidential in accordance with ss. 146.81 to 146.83, Stats. No privilege exists under the SeniorCare program regarding communications or disclosures of information requested by appropriate federal or state agencies or an authorized agent of such agencies concerning the extent or kind of services provided participants under the program. The disclosure by a SeniorCare provider of 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 for unprofessional conduct.

(3) PROVIDER RESPONSIBILITY. At the request of a person authorized by the department and on presentation of that person's credentials, a SeniorCare provider shall permit access to any

requested records, whether in written, electronic, or micrographic form. Access for purposes of this subsection shall include the opportunity to inspect, review, audit and reproduce the records.

(4) RECORD RETENTION. Termination of a SeniorCare provider's program participation does not end the SeniorCare provider's responsibility to retain and provide access to records unless an alternative arrangement for retention, maintenance and access has been established by the SeniorCare provider and approved in writing by the department.

(5) SUBMISSION OF CLAIMS. A SeniorCare provider shall submit all claims for drugs purchased by a participant during the spenddown and deductible periods.

(6) THIRD PARTY LIABILITY. A SeniorCare provider shall seek reimbursement from any third party insurer legally liable to contribute in whole or in part to the cost of prescription drugs prior to billing the SeniorCare program.

(7) REFUNDS TO PARTICIPANTS. A SeniorCare provider shall fully refund participant payments for drugs subsequently covered by SeniorCare. If either the deductible or copayment retroactively applies, the provider shall fully refund the participant the excess amount that the participant paid. The excess is the difference between the actual amount the participant paid and the amount the participant is responsible for under SeniorCare.

(8) LIMITATIONS ON COPAYMENTS AND DEDUCTIBLES. (a) Beginning on September 1, 2002, as a condition of participation by a SeniorCare provider in the program under s. 49.45, 49.46, or 49.47, Stats., the SeniorCare provider may not charge an eligible participant who presents a valid prescription order and a SeniorCare identification an amount for a prescription drug under the order that exceeds the following:

1. For a deductible benefit, as specified in s. HFS 109.13 (3), the program payment rate.

2. For a prescription benefit, the copayment amount, as applicable, that is specified in s. HFS 109.13 (2) (b). No dispensing fee may be charged to a person under this paragraph.

3. For persons receiving spenddown services, as specified in s. HFS 109.13 (4), the retail price.

(b) The department shall calculate and transmit amounts that may be used in calculating charges under par. (a) to SeniorCare providers.

HFS 109.52 Provider certification. (1) GENERAL. This section identifies the terms and conditions under which SeniorCare providers of drugs are certified for participation in the program.

(2) PHARMACIES. (a) For SeniorCare certification, pharmacies located in Wisconsin shall meet the requirements for registration and practice under ch. 450, Stats, and chs. Phar 1 to 14. Pharmacies certified to serve patients under the medical assistance program under ch. HFS 105 are required to serve SeniorCare participants.

(b) Pharmacies located outside of Wisconsin are exempt from the requirement under par. (a), but shall be registered or licensed by the appropriate agency in the state in which they are located.

(3) GENERAL CONDITIONS FOR PARTICIPATION. In order to be certified by the department to dispense drugs under this program, a SeniorCare provider shall do all of the following:

(a) Affirm in writing that the SeniorCare provider and each person employed by the SeniorCare provider for the purpose of providing the service holds all licenses or similar entitlements as specified in this chapter and as required by federal or state statute, regulation or rule for the provision of the service.

(b) Affirm in writing that neither the SeniorCare provider, nor any person in whom the SeniorCare provider has a controlling interest, nor any person having a controlling interest in the SeniorCare provider, has been convicted of a crime related to, or been terminated from, a federally-assisted or state-assisted medical program.

(c) Disclose in writing to the department all instances in which the SeniorCare provider, any person in whom the SeniorCare provider has a controlling interest, or any person having a controlling interest in the SeniorCare provider has been sanctioned by a federally-assisted or state-assisted medical program.

(d) Furnish the following information to the department in writing:

1. The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which the SeniorCare provider has a controlling interest or ownership.

2. The names and addresses of all persons who have a controlling interest in the SeniorCare provider.

3. Whether any of the persons named in compliance with subd. 1 or 2, is related to another named in subd. 1. or 2.

(e) Execute a SeniorCare provider agreement with the department.

(4) NOTIFICATION OF CERTIFICATION DECISION. Within 60 days after the department receives a complete application for certification, including evidence of licensure or Medicare certification, or both, if required, the department shall either approve the application and issue the certification, or deny the application. If the application for certification is denied, the department shall give the applicant reasons, in writing, for the denial.

(5) REQUIREMENTS FOR MAINTAINING CERTIFICATION. (a) *Compliance with requirements.* A SeniorCare provider shall maintain compliance with the requirements in this subsection in order to maintain SeniorCare certification.

(b) *Change in provider status.* A SeniorCare provider shall report to the department in writing any change in licensure, certification, group affiliation, corporate name or ownership by the time of the effective date of the change. The department may require the SeniorCare provider to complete a new provider application and a new provider agreement when a change in status occurs. A SeniorCare provider shall immediately notify the department of any change of address but the department shall not require the completion of a new provider application or a new provider agreement for a change of address.

Note: Providers can report changes by submitting a "Wisconsin change of address or status form" that is in the All-Provider Handbook. The form is also available at the Department's Medicaid website at: http://www.dhfs.state.wi.us/medicaid2/index.htm.

(c) *Change in ownership.* If the ownership of a certified SeniorCare provider changes, the provider agreement shall automatically terminate.

(d) *Program compliance.* A SeniorCare provider may lose SeniorCare certification for any of the reasons listed in sub. (12) of this section or in s. HFS 106.06.

(6) RESPONSE TO INQUIRIES. A SeniorCare provider shall respond as directed to inquiries by the department regarding the validity of provider information maintained by the department.

(7) MAINTENANCE OF RECORDS. A SeniorCare provider shall prepare and maintain whatever records are necessary to fully disclose the nature and extent of services provided by the SeniorCare provider under the program, including those enumerated in sub. (8). Each SeniorCare provider shall maintain all required records for at least a period of 5 years from the date the department pays for the services rendered, unless otherwise stated in this chapter. If a SeniorCare provider's participation in the program terminates for any reason, all related records shall remain subject to the conditions enumerated in this subsection and sub. (8).

(8) RECORDS TO BE MAINTAINED. SeniorCare providers shall retain all of the following records:

(a) Contracts or agreements with persons or organizations for the furnishing of SeniorCare items or services, payment for which may be made in whole or in part, directly or indirectly, by the department.

(b) Billings and records of services or supplies which are the subject of the billings that are necessary to fully disclose the nature and extent of the SeniorCare services or supplies.

(c) All policies and regulations adopted by the SeniorCare provider's governing body.

(d) Prescriptions that support SeniorCare billings.

(e) SeniorCare patient profiles.

(f) SeniorCare purchase invoices and receipts.

(g) Receipts for costs associated with SeniorCare services billed.

(9) PROVIDER AGREEMENT DURATION. The provider agreement shall, unless terminated, remain in full force and effect for a maximum of one year from the date the department accepts a SeniorCare provider into the program. In the absence of a notice of termination by the SeniorCare provider or department, the agreement shall automatically renew and extend for a period of one year.

(10) PARTICIPATION BY NON–CERTIFIED PERSONS. (a) *Reimbursement for emergency services.* If a person in Wisconsin or in another state who is not certified as a SeniorCare provider by the department in this state provides emergency services to a Wisconsin

participant, that person may not be reimbursed for those services unless the drugs are covered under this chapter and all of the following conditions are met:

1. The person submits to the department a provider data form and a claim for reimbursement of emergency services on forms prescribed by the department.

2. The person submits to the department a statement in writing on a form prescribed by the department explaining the nature of the emergency, if known, including a description of the participant's condition, cause of emergency, diagnosis and extent of injuries, the drugs that were provided and when, and the reason that the participant could not receive drugs from a certified SeniorCare provider.

3. The person possesses all licenses and other entitlements required under state and federal statutes, rules and regulations, and is qualified to provide all services for which a claim is submitted.

(b) *Reimbursement prohibited for non-emergency services.* The department may not reimburse non-emergency services provided by a non-certified person unless the department receives prior authorization as provided in s. HFS 109.32 (2).

(c) *Reimbursement determination.* Based upon the signed statement and the claim for reimbursement, the department shall determine whether the services are reimbursable.

(11) VOLUNTARY TERMINATION OF PROGRAM PARTICIPATION (a) *Voluntary termination.* Any SeniorCare provider may terminate participation in the SeniorCare program and the medical assistance program. A SeniorCare provider electing to terminate program participation shall, at least 30 days before the termination date, notify the department in writing of that decision, the reasons for termination and the effective date of termination from the program.

(b) *Reimbursement.* A SeniorCare provider may not claim reimbursement for drugs provided participants on or after the effective date specified in the termination notice. If the SeniorCare provider's notice of termination fails to specify an effective date, the department shall terminate the SeniorCare provider's certification to provide and claim reimbursement for services under the program on the date on which the department receives notice of termination.

(12) INVOLUNTARY TERMINATION OR SUSPENSION FROM PROGRAM PARTICIPATION. The provisions of s. HFS 106.06, pertaining to "Involuntary termination or suspension from program participation" apply to the SeniorCare program, with the exception of s. HFS 106.06 (3), (24) or (30).

(13) EFFECTS OF SUSPENSION OR INVOLUNTARY TERMINATION. The provisions of s. HFS 106.07, pertaining to "Effects of suspension or involuntary termination" apply to the SeniorCare program.

HFS 109.53 Department recovery of overpayments from SeniorCare providers. (1) RECOUPMENT METHODS. If the department finds that a SeniorCare provider has received an overpayment, including but not limited to erroneous, excess, duplicative and improper payments under the program, regardless of cause, the department may recover the amount of the overpayment by any of the following methods, at its discretion:

(a) Offsetting or making an appropriate adjustment against other amounts owed the SeniorCare provider for covered services.

(b) Offsetting or crediting against amounts the department determines are owed the SeniorCare provider for subsequent services provided under the program if both of the following conditions are met:

1. The amount owed the SeniorCare provider at the time of the department's finding is insufficient to recover in whole the amount of the overpayment.

2. The SeniorCare provider is claiming and receiving SeniorCare reimbursement in amounts sufficient to reasonably ensure full recovery of the overpayment within a reasonable period of time.

(c) Requiring the SeniorCare provider to pay directly to the department the amount of the overpayment.

(2) WRITTEN NOTICE. No recovery by offset, adjustment or demand for payment may be made by the department under sub. (1), except as provided under sub. (3), unless the department gives the SeniorCare provider prior written notice of the department's intention to recover the amount determined to have been overpaid. The notice shall set forth the amount of the intended recovery, the method of the intended recovery, identify the claim or claims in question or other basis for recovery, summarize the basis for the department's finding that the SeniorCare provider has received amounts to which the SeniorCare provider is not entitled or in excess of that to which the SeniorCare provider is entitled, and inform the SeniorCare provider of a right to appeal the intended action under sub. (5). The SeniorCare provider shall make payment due the department within 30 days after the date of service of the notice of intent to recover. The department shall send final notices of intent to recover by certified mail.

(3) EXCEPTION. The department need not provide prior written notice under sub. (2) when the overpayment was made as a result of a computer processing or clerical error, for a recoupment of a manual partial payment, or when the SeniorCare provider requested or authorized the recovery to be made. In any of these cases, the department shall provide written notice of any payment adjustments made on the next remittance issued the SeniorCare provider. The notice shall specify the amount of the adjustment made and the claim that was the subject of the adjustment.

(4) WITHHOLDING OF PAYMENT INVOLVING FRAUD OR WILLFUL MISREPRESENTATION. (a) The department may withhold SeniorCare payments, in whole or in part, to a SeniorCare provider upon the department's receipt of reliable evidence that the circumstances giving rise to the need for withholding payments involve fraud or willful misrepresentation under the SeniorCare program. Reliable evidence of fraud or willful misrepresentation includes a prosecuting attorney's filing of criminal charges against the SeniorCare provider or one of its agents or employees. The department may withhold payments without first notifying the SeniorCare provider of its intention to withhold the payments.

(b) The department shall send written notice to the SeniorCare provider of the department's withholding of SeniorCare program payments within 5 calendar days after taking that action. The notice shall generally set forth the allegations leading to the withholding, but need not disclose any specific information concerning the ongoing investigation of allegations of fraud and willful misrepresentation. The notice shall provide all of the following information:

1. A statement that payments are being withheld in accordance with this paragraph.

2. A statement that the withholding action is for a temporary period, as defined under par. (c), and that cites the circumstances under which withholding will be terminated.

3. When appropriate, a statement specifying to which type of SeniorCare claims withholding is effective.

4. A statement informing the SeniorCare provider that the provider has a right to submit to the department written evidence regarding the allegations of fraud and willful misrepresentation for consideration by the department.

(c) Withholding of the SeniorCare provider's payments shall be temporary. Payment withholding may not continue after any of the following events occurs:

1. The department determines after a preliminary investigation there is not sufficient evidence of fraud or willful misrepresentation by the SeniorCare provider to require referral of the matter to an appropriate law enforcement agency and, to the extent of the department's knowledge, the matter is not already the subject of an investigation or a prosecution by a law enforcement agency or a prosecuting authority.

2. Any law enforcement agency or prosecuting authority that has investigated or commenced prosecution of the matter determines there is insufficient evidence of fraud or misrepresentation by the SeniorCare provider to pursue criminal charges or civil forfeitures.

3. Legal proceedings relating to the SeniorCare provider's alleged fraud or willful misrepresentation are completed and charges against the provider have been dismissed. In the case of a conviction of a SeniorCare provider for criminal or civil forfeiture offenses, those proceedings shall not be regarded as being completed until all appeals are exhausted. In the case of an acquittal in or dismissal of criminal or civil forfeiture proceedings against a SeniorCare provider, the proceedings shall be regarded as complete at the time of dismissal or acquittal regardless of any opportunities for appeal the prosecuting authority may have.

(5) REQUEST FOR HEARING ON RECOVERY ACTION. If a SeniorCare provider chooses to contest the propriety of a proposed recovery under sub. (1), the SeniorCare provider shall, within 20 days after receipt of the department's notice of intent to recover, request a hearing on the matter. The request shall be submitted in writing to the department of administration's division of hearings and appeals and shall briefly identify the basis for contesting the proposed recovery. The date of service of a SeniorCare provider's request for a hearing shall be the date on which the department of administration's division of hearing and appeals receives the request. Receipt of a timely request for hearing shall prevent the department from making the proposed recovery while the hearing proceeding is pending. If a timely request for hearing is not received, the department may recover from current or future obligations of the program to the SeniorCare provider the amount specified in the notice of intent to recover and may take such other legal action as it deems appropriate to collect the amount specified. All hearings on recovery actions by the department shall be held in accordance with the provisions of ch. 227, Stats.

Note: A hearing request should be mailed to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707, 608–266–3096. Hearing requests may be delivered in person to that office at 5005 University Ave., Room 201, Madison, Wisconsin or transmitted by facsimile machine to 608-264-9885.

HFS 109.54 Incorporation of Medicaid standards. The following provisions applicable to the medical assistance program apply to SeniorCare providers for acts and activities pertaining to the SeniorCare program:

(1) GENERAL REQUIREMENTS FOR PROVISION OF SERVICES. The provisions of s. HFS 106.02 apply to the SeniorCare program.

(2) MANNER OF PREPARING AND SUBMITTING CLAIMS FOR REIMBURSEMENT. With the exception of s. HFS 106.03 (2) (d), (3) (c) 3. and (5) (br), the provisions of s. HFS 106.03 apply to the SeniorCare program.

(3) PAYMENT OF CLAIMS FOR REIMBURSEMENT. With the exception of s. HFS 106.04 (2) and (3) (b) and (c), the provisions of s. HFS 106.04 apply to the SeniorCare program.

(4) INTERMEDIATE SANCTIONS. The provisions of s. HFS 106.08 apply to the SeniorCare program.

(5) DEPARTMENTAL DISCRETION TO PURSUE MONETARY RECOVERY. The provisions of s. HFS 106.09 (1) apply to the SeniorCare program.

(6) WITHHOLDING PAYMENT OF CLAIMS. The provisions of s. HFS 106.10 apply to the SeniorCare program.

(7) PREPAYMENT REVIEW OF CLAIMS. The provisions of s. HFS 106.11 apply to the SeniorCare program.

(8) PROCEDURE, PLEADINGS AND PRACTICE. The provisions of s. HFS 106.12 apply to the SeniorCare program.

Subchapter VI - Participant Rights and Responsibilities

HFS 109.61 Participant duties. (1) NOT TO SEEK DUPLICATION OF SERVICES. A participant may not seek the same or similar drugs from more than one SeniorCare provider.

(2) PRIOR IDENTIFICATION OF ELIGIBILITY. Except in emergencies that preclude prior identification, the participant shall, before receiving drugs, inform the SeniorCare provider that the participant is receiving benefits under SeniorCare and shall present to the SeniorCare provider a current valid SeniorCare identification card.

(3) REVIEW OF BENEFITS NOTICE. Participants shall review the explanation of benefits (EOB) notice sent to them by the department and shall report to the department any payments made for drugs not actually provided.

(4) INFORMATIONAL COOPERATION WITH SENIORCARE PROVIDERS. Participants shall give SeniorCare providers full, correct and truthful information requested by SeniorCare providers and necessary for the submission of correct and complete claims for SeniorCare reimbursement, including information about all of the following:

(a) The participant's eligibility status, accurate name, address and SeniorCare identification number.

(b) The participant's use of the SeniorCare card.

(c) The participant's use of SeniorCare benefits.

(d) The participant's coverage under other insurance programs.

(5) NOT TO ABUSE OR MISUSE THE SENIORCARE CARD OR BENEFITS. If a participant abuses or misuses the SeniorCare card or SeniorCare benefits in any manner, the department may terminate benefits or limit access to benefits under s. HFS 109.31 (4). For purposes of this subsection, "abuses or misuses" includes any of the following actions:

(a) Altering or duplicating the SeniorCare card in any manner.

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

(c) Using a SeniorCare card that belongs to a person not authorized under that card.

(d) Using the SeniorCare 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 SeniorCare provider.

(h) Knowingly furnishing false information to a SeniorCare provider in connection with health care previously rendered to the participant and for which SeniorCare has been billed.

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

(j) Otherwise obtaining health care by false pretenses.

HFS 109.62 Recovery of incorrect payments from participants. (1) The department shall begin recovery action against any SeniorCare participant to whom or on whose behalf an incorrect payment was made resulting from a misstatement or omission of fact by the person supplying information in an application, a request for a new benefit period, or review of eligibility for SeniorCare benefits.

(2) The amount of recovery may not exceed the amount of the SeniorCare benefits incorrectly provided.

(3) Department records of payment for the period of ineligibility shall be evidence of the amounts paid on behalf of the participant.

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

(5) If the department does not recover incorrect payments under sub. (4), the department shall refer cases of possible recovery to the district attorney or corporation counsel for investigation and the district attorney or corporation counsel may bring whatever action may be appropriate for prosecution for fraud or collection under civil liability statutes. If not satisfied at the time the judgment or order for restitution is rendered, judgments obtained in these actions shall be filed as liens against property in any county in which the participant is known to possess assets. Execution may be taken on the judgments as otherwise provided in statute.

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

HFS 109.63 Participant appeals. Any participant who is aggrieved by the department's action or inaction may file an appeal pursuant to the requirements under ch. HA 3 that apply to the medical assistance program, except for s. HA 3.05 (2) (a). The participant shall have 45 days from the effective date of the adverse action in which to file a request for hearing. A request for a hearing concerning the SeniorCare program may only be made in writing and only to the Division of Hearings and Appeals.

Note: A hearing request should be mailed to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI, 53707-7875. Hearing requests may be delivered in person to that office at 5005 University Ave., Room 201, Madison, Wisconsin or transmitted by facsimile machine to 608-264-9885.

Subchapter VII - Program Administration

HFS 109.71 Rebate agreement. The department shall provide to a drug manufacturer that sells drugs for prescribed use in this state documents designed for use by the manufacturer in entering into a rebate agreement with the department. The manufacturer shall make rebate payments for each prescription drug of the manufacturer that is prescribed for and purchased by persons under s. HFS 109.13 (2) (b) and (3) (b), to the state treasurer to be credited to the appropriation account under s. 20.435 (4) (j), Stats., each calendar quarter or according to a schedule established by the department.

HFS 109.72 Payment for drugs. The department shall provide to SeniorCare providers payments for prescription drugs sold by the SeniorCare providers to eligible persons under s. HFS 109.13 (2) (b). The payment for each prescription drug under this subsection shall be no more than the program payment rate, minus any copayment paid by the person under s. HFS 109.13 (2) (b).

HFS 109.73 Safeguarded information. (1) Except for purposes directly related to direct program administration, the department may not use or disclose any information concerning past or present applicants and participants in SeniorCare.

(2) For purposes of direct program administration, the department may permit disclosure to, or use of safeguarded information by, legally qualified persons or agency representatives outside the department. Governmental authorities, the courts, and law enforcement officers are persons outside the department who shall comply with sub. (3).

(3) Persons or agency representatives outside the department to whom the department may disclose or permit use of safeguarded information shall meet all of the following qualifications:

(a) The persons' or agency representatives' purpose for use or disclosure shall involve direct program administration.

(b) The person or agency shall be bound by law or other legally enforceable obligation to observe confidentiality standards comparable to those observed by the department.

The rules contained in this order shall take effect on September 1, 2002 as provided in ss. 227.22 (2) (c) and 227.24 (1) (c), Stats.

Wisconsin Department of Health and Family Services

By: Phyllis J. Dubé
Phyllis J. Dubé
Secretary

Date August 29, 2002

Seal: