Chapter HFS 109

SENIOR CARE

Note: Chapter HFS 109 was created as an emergency rule effective September 1, 2002.

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.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

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.

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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 an MA certified pharmacist, pharmacy or dispensing physician.

(16) "Spend–down" 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) "Spend–down 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.

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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 by the department 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. The applicant, participant, or person described in par. (d) acting on behalf of the applicant or participant shall report changes in circumstances that may affect eligibility 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 may verify information provided by the applicant in the application under sub. (2) 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, 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 from program*. 1. Deadline for refund of enrollment fee. 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:

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

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

2. A recipient may ask to withdraw from the program after the deadline in subd. 1., but will not receive a refund of the enrollment fee.

3. The effective date of a withdrawal under this paragraph will be the date the department issues a notice of decision concerning the withdrawal.

(e) *Applications during program suspensions*. If the department makes the determination under s. 49.688 (7) (b), Stats., to suspend benefits and services for new applicants or the entire program, the department shall continue to process applications and determine eligibility while the suspension is in effect.

(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.

(d) When the department learns that the program enrollment fee payment has been returned for non−sufficient funds and the recipient fails to provide the enrollment fee within 10 days of the date the department sends a letter requesting payment.

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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 spend−down 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 spend−down 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.

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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. Except during a period of program suspension under s. 49.688 (7) (b), Stats., SeniorCare benefits and services shall be available only 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 spend−down 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 spend–down 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 may 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. No participant may be required to pay the copayment under sub. (2) (b) for that prescription.

(4) SPEND–DOWN SERVICES. (a) *Income category applicability.* 1. A person may receive the SeniorCare spend–down 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 spend–down services and shall inform participating SeniorCare providers when he or she has met the spend–down within the benefit period as described in par. (c).

(b) *Amount*. The amount of a person's SeniorCare spend–down 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 spend–down.* A SeniorCare spend–down 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 spend–down 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 may be counted toward meeting the spend–down 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 may be counted toward meeting the spend–down 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 spend–down.

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 may be counted toward meeting the spend–down.

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

6. Only claims submitted by a SeniorCare provider may be considered in determining whether the participant has met the spend–down.

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

(5) REVIEW OF BENEFITS. After the department learns of an error or omission in the information on the application form or other information provided by the recipient used to determine the benefits and services, the department shall promptly redetermine which SeniorCare benefits and services a participant may receive under this section. The benefits and services may only be changed if the error or omission is of factual information available to the recipient at the time he or she filed the application.

(6) CORRECTION OF BENEFITS. The department shall correct in the following ways the benefits and services received in error under this section:

(a) For underpayment errors caused by the department, benefits will be corrected back to the beginning of the benefit period.

(b) For underpayment errors caused by the recipient when the recipient reports the error within 45 days after the date of the initial eligibility notice, benefits will be corrected back to the beginning of the benefit period.

(c) For underpayment errors caused by the recipient when the recipient reports the error more than 45 days after the date of the initial eligibility notice, benefits will be corrected back to the first of the month in which the error was reported.

(d) For overpayment errors, benefits will be corrected beginning the first of the month following the issuance by the department of a timely notice of decision under s. HFS 109.11 (5) (b). Recovery of benefits issued in error shall be in accordance with s. HFS 109.62.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

HFS 109.14 SeniorCare benefit period. (1) DURATION. Except as provided in subs. (3) to (5), and in s. HFS 109.15 and s. 49.688 (7) (a), Stats., 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, or who requests a withdrawal from the program under s. HFS 109.11 (5) (d).

(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.

(c) The department shall reinstate the SeniorCare benefit period for a person who has requested a withdrawal from the program under s. HFS 109.11 (5) (d) if within 30 calendar days of the effective date of the withdrawal both of the following occur:

1. The department receives the person's request to have SeniorCare benefits restored.

2. The person meets all of the eligibility criteria under s. HFS 109.11, including a new payment of the program enrollment fee specified in s. HFS 109.16 for persons who were issued a refund under s. HFS 109.11 (5) (d) 1.

(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 s. HFS 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 spend–down or deductible in a previous benefit period may 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.

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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 of eligibility for SeniorCare under s. HFS 109.14 (7), 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 may 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 shall 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 spend–down services under s. HFS 109.13 (4) (a) 2.

b. When determining whether the spouse meets the SeniorCare spend–down under s. HFS 109.13 (4) (c), the amount of the SeniorCare spend–down shall be prorated. The prorated amount shall be the annual spend–down 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 spend–down.

c. If the spouse meets the prorated spend–down 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 family, 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 spend–down.' 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 spend–down by the date the spouse becomes eligible for SeniorCare, the spouse may receive spend–down services under s. HFS 109.13 (4).

2. 'Participant has met spend–down.' 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 spend–down before the spouse becomes eligible for SeniorCare, or the participant and spouse meet the spend–down 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 s. HFS 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).

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

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

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

HFS 109.17 Applicant appeals. (1) Except as provided under sub. (2), 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 the person 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.

(2) (a) A request for a hearing concerning the SeniorCare program may only be made in writing and only to the Division of Hearings and Appeals.

(b) The applicant shall have 45 days from the effective date of the adverse action in which to file a request for hearing.

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.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

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. 447.04, 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, spend–down 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 made by a provider under sub. (1), the department shall require the information required in s. HFS 107.02 (3) (d) and apply the review criteria in s. HFS 107.02 (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 subd. 2. a., the department may not cover a prescription drug or apply a participant's purchase to the deductible or spend–down 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 depart-

ment 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 under s. HFS 109.63. 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 specified under s. HFS 107.10 (3) (e), in amounts up to but not to exceed a 100–day supply, as prescribed by a physician.

Note: The maintenance drugs listed in section HFS 107.10 (3) (e) are: digoxin, digitoxin, digitalis; hydrochlorothiazide and chlorothiazide; prenatal vitamins; fluoride; levothyroxine, liothyronine and thyroid extract; phenobarbital; phenytoin; and oral contraceptives.

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

(g) The innovator of a multiple–source drug shall be a covered service only 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.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

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) As a result of an accident or sudden illness, the individual needs the drug to prevent the individual's death or the serious impairment of the individual's health.

(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.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

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.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

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.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

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 spend–down 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) 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 spend–down 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.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

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 applica-

tion 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 may 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) 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.

Note: Providers may 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.

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 apply to the SeniorCare program, with the exception of s. HFS 106.06 (3), (24) and (30).

(13) EFFECTS OF SUSPENSION OR INVOLUNTARY TERMINATION. The provisions of s. HFS 106.07 apply to the SeniorCare program.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

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 is not required to provide 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 may 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.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

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.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

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 covered 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.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

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 any of the following:

(a) A misstatement or omission of fact by the person supplying information on an application, a request for a new benefit period, or a review of eligibility for SeniorCare benefits.

(b) A check submitted for the program enrollment fee is returned for non–sufficient funds under s. HFS 109.11 (6) (d).

(c) A recipient fails to inform the department, within 10 calendar days of the change, of changes in circumstances that affect eligibility.

(d) A recipient received benefits while an appeal requested under s. HFS 109.63 was pending and the contested decision is upheld.

(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.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

HFS 109.63 Participant appeals. (1) Except as provided under sub. (2), 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.

(2) (a) A request for a hearing concerning the SeniorCare program may only be made in writing and only to the Division of Hearings and Appeals.

(b) The participant shall have 45 days from the effective date of the adverse action in which to file a request for hearing.

(3) If a recipient requests a hearing before the effective date of the action, SeniorCare benefits and services may not be suspended, reduced or discontinued until a decision is rendered after the hearing. However, SeniorCare benefit payments made pending the hearing decision may be recovered by the department if the contested decision or failure to act is upheld.

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.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

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.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

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).

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

HFS 109.73 Program suspension. During any period in which funding under s. 20.435 (4) (bv), Stats., is completely expended for the payments to SeniorCare providers, the requirements of ss. HFS 109.71 and 109.72 do not apply to drugs purchased during that period. However, the department shall continue to accept applications and determine eligibility under subchapter II and shall indicate to applicants that the eligibility of program participants to purchase prescription drugs as specified in this chapter, under the requirements of s. HFS 109.72, is conditioned on the availability of funding under s. 20.435 (4) (bv), Stats.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.

HFS 109.74 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.

History: CR 02–154: cr. Register April 2003 No. 568, eff. 5–1–03.