STATEMENT OF SCOPE
WISCONSIN DEPARTMENT OF HEALTH SERVICES

CHAPTER: DHS 10, 101, 105, 106, and 107
RELATING TO: Medical Assistance Electronic Visit Verification
RULE TYPE: Permanent and Emergency
SCOPE TYPE: Original

FINDINGS OF EMERGENCY:

In order to comply with federal law and continue to receive the full medical assistance percentage ("FMAP"), Wisconsin must establish a requirement that personal and home health agencies utilize an electronic visit verification system ("EVV"). The Department has established an EVV launch date of May 1, 2023. New administrative rules are necessary to implement and enforce these requirements, but it will be impossible to promulgate permanent rules that comply with all of the requirements of ch. 227, Stats., by that launch date. If the State does not implement this change by the launch date, the FMAP it receives will gradually decrease up to one percentage point until the program has begun. Thus, preservation of the public welfare public welfare—namely the department's compliance with federal law and the continued receipt of its FMAP—necessitates putting an emergency rule into effect prior to the time a permanent rule would take effect if the agency complied with all of the statutory procedures under ch. 227, Stats.

SUMMARY

1. Description of rule objective/s

Section 1903 (1) of the Social Security Act, 42 U.S.C. 1396b (l), as amended by the 21st Century Cures Act, Pub. L. No. 114-255 ("the Cures Act") established the requirement that state Medical Assistance programs utilize an electronic visit verification system for personal care and home health services in order to continue receiving the full federal medical assistance percentage for those services under Title XIX of the Social Security Act. In order to comply with, and effectively enforce, the electronic visit verification requirements created by the Cures Act, the department of health services ("the department") intends to establish Medical Assistance program regulations regarding electronic visit verification.

2. Existing policies relevant to the rule

DHS 10 Family Care
DHS 101 Introduction and Definitions
DHS 105 Provider Certification
DHS 106 Provider Rights and Responsibilities
DHS 107 Covered Services

3. Policies proposed to be included in the rule

The department intends to promulgate administrative rules necessary to effectuate the use of an electronic visit verification system for Medical Assistance personal care and home health services in compliance with the Cures Act.

4. Analysis of policy alternative

There are no reasonable alternatives to the proposed rulemaking. The department is unable to effectively enforce the use of the electronic visit verification system by personal care and home health services providers without establishing administrative rules.

5. Statutory authority for the rule

a. Explanation of authority to promulgate the proposed rule

The department's authority to promulgate the proposed rules is provided in ss. 46.288 (1), 49.45 (1), (2) (a) 1. and 2., 7., 11. a. and b., 12. a. and b.,13., (b) 4., (3) (f) 2., and (10), 49.46 (2) (b); 49.47 (6) (a), and 49.471 (12) (a) 1., Stats.

b. Statute/s that authorize/s the promulgation of the proposed rule

Section 46.288, Stats., reads:

Rulemaking. The department shall promulgate as rules all of the following:
(1) Standards for performance by resource centers and for certification of care management organizations, including requirements for maintaining quality assurance and quality improvement.

Section 49.45 (1), (2) (a) 1. and 2., 7., 11. a. and b., 12. a. and b.,13., (b) 4., (3) (f) 2., and (10), Stats., reads:

(1) PURPOSE. To provide appropriate health care for eligible persons and obtain the most benefits available under Title XIX of the federal social security act, the department shall administer medical assistance, rehabilitative and other services to help eligible individuals and families attain or retain capability for independence or self−care as hereinafter provided.
(2) DUTIES.
(a) The department shall:
1. Exercise responsibility relating to fiscal matters, the eligibility for benefits under standards set forth in ss. 49.46 to 49.471, and general supervision of the medical assistance program.
2. Employ necessary personnel under the classified service for the efficient and economical performance of the program and shall supply residents of this state with information concerning the program and procedures.
. . . 7. Cooperate with the federal authorities for the purpose of providing the assistance and services available under Title XIX to obtain the best financial reimbursement available to the state from federal funds.
. . . 11.
a. Establish criteria for certification of providers of medical assistance and, except as provided in par. (b) 6m. and s. 49.48, and subject to par. (b) 7. and 8., certify providers who meet the criteria.
b. Promulgate rules to implement this subdivision.
. . . 12.
a. Decertify a provider from or restrict a provider's participation in the medical assistance program, if after giving reasonable notice and opportunity for hearing the department finds that the provider has violated a federal statute or regulation or a state statute or administrative rule and the violation is, by statute, regulation, or rule, grounds for decertification or restriction. The department shall suspend the provider pending the hearing under this subdivision if the department includes in its decertification notice findings that the provider's continued participation in the medical assistance program pending hearing is likely to lead to the irretrievable loss of public funds and is unnecessary to provide adequate access to services to medical assistance recipients. As soon as practicable after the hearing, the department shall issue a written decision. No payment may be made under the medical assistance program with respect to any service or item furnished by the provider subsequent to decertification or during the period of suspension.
b. Promulgate rules to implement this subdivision.
. . .
13. Impose additional sanctions for noncompliance with the terms of provider agreements under subd. 9. or certification criteria established under subd. 11.
. . .(b) The department may:
. . . 4. Audit claims filed by any provider of medical assistance, and as part of that audit, request of any such provider, and review, medical records of individuals who have received benefits under the medical assistance program.
(3) PAYMENT.
. . . (f)
. . . 2. The department may deny any provider claim for reimbursement which cannot be verified under subd. 1. or may recover the value of any payment made to a provider which cannot be so verified. The measure of recovery will be the full value of any claim if it is determined upon audit that actual provision of the service

cannot be verified from the provider's records or that the service provided was not included in s. 49.46 (2) or 49.471 (11). In cases of mathematical inaccuracies in computations or statements of claims, the measure of recovery will be limited to the amount of the error.

. . . (10) RULE−MAKING POWERS AND DUTIES. The department is authorized to promulgate such rules as are consistent with its duties in administering medical assistance. The department shall promulgate a rule defining the term "part−time intermittent care" for the purpose of s. 49.46.

Section 49.46 (2) (b), Stats., reads:

(2) BENEFITS.

. . . (b) Except as provided in pars. (be) and (dc), the department shall audit and pay allowable charges to certified providers for medical assistance on behalf of recipients for the following services:

…

6. The following services that, other than under subd. 6. f., fm., k., and Lr., are prescribed or ordered by a provider acting within the scope of the provider's practice under statutes, rules, or regulations that govern the provider's practice:

a. Intermediate care facility services other than in an institution for mental diseases, except as limited under s. 49.45 (30m) (b) and (c).

b. Physical and occupational therapy.

c. Speech, hearing and language disorder services.

d. Medical supplies and equipment.

dm. Subject to the requirements under s. 49.45 (9r), durable medical equipment that is considered complex rehabilitation technology, excluding speech generating devices.

e. Subject to the limitation under s. 49.45 (30r), inpatient hospital, skilled nursing facility and intermediate care facility services for patients of any institution for mental diseases who are under 21 years of age, are under 22 years of age and who were receiving these services immediately prior to reaching age 21, are 65 years of age or older, or are otherwise permitted under s. 49.45 (53m).

f. Medical day treatment services, mental health services and alcohol and other drug abuse services, including services provided by a psychiatrist.

fm. Subject to the limitations under s. 49.45 (45), mental health services and alcohol and other drug abuse services, including services provided by a psychiatrist, to an individual who is 21 years of age or older in the individual's home or in the community.

g. Nursing services as defined in rules that the department shall promulgate.

h. Legend drugs, as listed in the Wisconsin medical assistance drug index.

i. Over−the−counter drugs listed by the department in the Wisconsin medical assistance drug index.

j. Personal care services, subject to the limitation under s. 49.45 (42).

k. Alcohol and other drug abuse day treatment services.

L. Mental health and psychosocial rehabilitative services, including case management services, provided by the staff of a community support program certified under s. 49.45 (2) (a) 11.

Lm. Subject to the limitations under s. 49.45 (30e), psychosocial services, including case management services, provided by the staff of a community−based psychosocial service program.

Lo. Subject to the limitations under s. 49.45 (30g), community recovery services.

Lr. Psychotherapy and alcohol and other drug abuse services, as specified under s. 49.45 (30f).

m. Respiratory care services for ventilator−dependent individuals.

8. Home or community−based services, if provided under s. 46.275, 46.277, 46.278, 46.2785, 46.99, or under the family care benefit if a waiver is in effect under s. 46.281 (1d), or under the disabled children's long−term support program, as defined in s. 46.011 (1g).

9. Case management services, as specified under s. 49.45 (24) or (25).

10. Hospice care as defined in 42 USC 1396d (o) (1).

…

18. Care coordination, as specified under s. 49.45 (25g).

…

20. Subject to s. 49.45 (24j), any additional services, as determined by the department, that are targeted to a population enrolled in a medical home initiative under s. 49.45 (24j).

…

Section 49.47 (6) (a), Stats., reads:(6) BENEFITS.
(a) The department shall audit and pay charges to certified providers for medical assistance on behalf of the following:
1. Except as provided in subds. 6. to 7., all beneficiaries, for all services under s. 49.46 (2) (a) and (b), subject to s. 49.46 (2) (dc).
6. a. In this subdivision, "entitled to coverage under part A of medicare" means eligible for and enrolled in part A of medicare under 42 USC 1395c to 1395f.
ag. In this subdivision, "entitled to coverage under part B of medicare" means eligible for and enrolled in part B of medicare under 42 USC 1395j to 1395L.
ar. In this subdivision, "income limitation" means income that is equal to or less than 100 percent of the poverty line, as established under 42 USC 9902 (2).
b. An individual who is entitled to coverage under Part A of Medicare, entitled to coverage under Part B of Medicare, meets the eligibility criteria under sub. (4) (a), and meets the income limitation, the deductible and coinsurance portions of Medicare services under 42 USC 1395 to 1395zz that are not paid under 42 USC 1395 to 1395zz, including those Medicare services that are not included in the approved state plan for services under 42 USC 1396; the monthly premiums payable under 42 USC 1395v; the monthly premiums, if applicable, under 42 USC 1395i–2 (d); and the late enrollment penalty, if applicable, for premiums under Part A of Medicare. Payment of coinsurance for a service under Part B of Medicare under 42 USC 1395j to 1395w and payment of deductibles and coinsurance for inpatient hospital services under Part A of Medicare may not exceed the allowable charge for the service under Medical Assistance minus the Medicare payment.
c. An individual who is only entitled to coverage under Part A of Medicare, meets the eligibility criteria under sub. (4) (a), and meets the income limitation, the deductible and coinsurance portions of Medicare services under 42 USC 1395 to 1395i that are not paid under 42 USC 1395 to 1395i, including those Medicare services that are not included in the approved state plan for services under 42 USC 1396; the monthly premiums, if applicable, under 42 USC 1395i–2 (d); and the late enrollment penalty, if applicable, for premiums under Part A of Medicare. Payment of deductibles and coinsurance for inpatient hospital services under Part A of Medicare may not exceed the allowable charge for the service under Medical Assistance minus the Medicare payment.
d. An individual who is entitled to coverage under Part A of Medicare, entitled to coverage under Part B of Medicare, and meets the eligibility criteria for Medical Assistance under sub. (4) (a), but does not meet the income limitation, the deductible and coinsurance portions of Medicare services under 42 USC 1395 to 1395zz that are not paid under 42 USC 1395 to 1395zz, including those Medicare services that are not included in the approved state plan for services under 42 USC 1396. Payment of coinsurance for a service under Part B of Medicare under 42 USC 1395j to 1395w and payment of deductibles and coinsurance for inpatient hospital services under Part A of Medicare may not exceed the allowable charge for the service under Medical Assistance minus the Medicare payment.
e. An individual who is only entitled to coverage under Part A of Medicare and meets the eligibility criteria for Medical Assistance under sub. (4) (a), but does not meet the income limitation, the deductible and coinsurance portions of Medicare services under 42 USC 1395 to 1395i, including those services that are not included in the approved state plan for services under 42 USC 1396. Payment of deductibles and coinsurance for inpatient hospital services under Part A of Medicare may not exceed the allowable charge for the service under Medical Assistance minus the Medicare payment.
f. For an individual who is only entitled to coverage under Part B of Medicare and meets the eligibility criteria under sub. (4), but does not meet the income limitation, Medical Assistance shall include payment of the deductible and coinsurance portions of Medicare services under 42 USC 1395j to 1395w, including those Medicare services that are not included in the approved state plan for services under 42 USC 1396. Payment of coinsurance for a service under Part B of Medicare may not exceed the allowable charge for the service under Medical Assistance minus the Medicare payment.
6m. An individual who is entitled to coverage under part A of medicare, as defined in subd. 6. a. is entitled to coverage under part B of medicare, as defined in subd. 6. ag. and meets the eligibility criteria under sub. (4) (a) and whose income is greater than 100 percent of the poverty line but less than 120 percent of the poverty line for the monthly premiums under 42 USC 1395r.

7. Beneficiaries eligible under sub. (4) (ag) 2. or (am) 1., for services under s. 49.46 (2) (a) and (b) that are related to pregnancy, including postpartum services and family planning services, as defined in s. 253.07 (1) (b), or related to other conditions which may complicate pregnancy.

Section 49.471 (12) (a) 1., Stats., reads:
(12) RULES; NOTICE OF EFFECTIVE DATE.
(a)
1. The department may promulgate any rules necessary for and consistent with its administrative responsibilities under this section, including additional eligibility criteria.

Section 227.24 (1) (a), Stats., reads:
An agency may, except as provided in s. 227.136 (1), promulgate a rule as an emergency rule without complying with the notice, hearing, and publication requirements under this chapter if preservation of the public peace, health, safety, or welfare necessitates putting the rule into effect prior to the time it would take effect if the agency complied with the procedures.

c. Statute/s or rule/s that will affect the proposed rule or be affected by it

DHS 10 - Family Care
DHS 101 - Introduction and Definitions
DHS 105 - Provider Certification
DHS 106 - Provider Rights and Responsibilities
DHS 107 - Covered Services

6. Estimates of the amount of time that state employees will spend to develop the rule and other necessary resources

The estimated time for state employees to develop the rule is 2,080 hours.

7. Description of all of the entities that may be affected by the rule, including any local governmental units, businesses, economic sectors, or public utility ratepayers who may reasonably be anticipated to be affected by the rule

— The department.

— Medical Assistance members receiving personal care and home health services.

— Provider agencies and workers providing Medical Assistance personal care and home health services.

— Include, Respect, I Self-Direct ("IRIS") consultant agencies and IRIS fiscal employer agencies.

— Medical Assistance health maintenance organizations and care management organizations providing personal care and home health services.

— Tribal governing bodies and providers providing Medical Assistance personal care and home health services.

8. Summary and preliminary comparison of any existing or proposed federal regulation that is intended to address the activities to be regulated by the rule

Section 1903(l) of the Social Security Act requires Medical Assistance programs to utilize an electronic visit verification system for personal care and home health services in order to gain the maximum amount of federal matching funds available to a state. The following personal care and home health service visit information is required to be electronically verified:

— the type of service performed;

— the individual receiving the service;

— the date of the service;

— the location of service delivery;

— the individual providing the service; and

— the time the service begins and ends.

42 CFR Subpart C establishes regulations of Medical Assistance program mechanized claims processing and information retrieval systems. 42 CFR 433.112(b)(14) requires Medical Assistance programs to claims systems support accurate and timely processing.

9. Anticipated economic impact, locally or statewide

The proposed rule may have a significant economic impact.

10. Agency contacts

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