DMHF Rules Matrix 9-21-23

Rule Summary	Bulletin Publication	Effective
R414-522 Electronic Visit Verification Requirements for Personal Care and Home Health Care Services; The purpose of this change is to correct the effective date of the electronic visit verification (EVV) requirement. This amendment, therefore, updates the effective date of the EVV requirement and clarifies when providers must submit EVV records.	**9-1-23**	**10-9-23**
R414-515 Long Term Acute Care; The purpose of this change is to update and clarify policy for long-term acute care. This amendment, therefore, updates and clarifies eligibility, access, coverage, prior authorization, and reimbursement for long-term acute care. It also makes other technical changes.	**9-15-23**	**10-23-23**

The public may access proposed rules published in the State Bulletin at https://rules.utah.gov/publications/utah-state-bull/

State of Utah
Administrative Rule Analysis
Revised May 2023

NOTICE OF PROPOSED RULE		
TYPE OF FILING: Amendment		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R414-522**	**Filing ID: Office Use Only**

Agency Information

1. Department:	Department of Health and Human Services	
Agency:	Division of Integrated Healthcare	
Room number:		
Building:	Cannon Health Building	
Street address:	288 North 1460 West	
City, state and zip:	Salt Lake City, UT 84116	
Mailing address:	PO Box 143102	
City, state and zip:	Salt Lake City, UT 84114-3102	
Contact persons:		
Name:	**Phone:**	**Email:**
Craig Devashrayee	(801) 538-6641	cdevashrayee@utah.gov
Jonah Shaw	(385) 310-2389	jshaw@utah.gov
Please address questions regarding information on this notice to the persons listed above.		

General Information

2. Rule or section catchline:
R414-522. Electronic Visit Verification Requirements for Personal Care and Home Health Care Services.
3. Purpose of the new rule or reason for the change:
The purpose of this change is to correct the effective date of the electronic visit verification (EVV) requirement.
4. Summary of the new rule or change:
This amendment updates the effective date of the EVV requirement and clarifies when providers must submit EVV records.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:
A) State budget:
There is no impact to the state budget as this amendment only clarifies current EVV requirements, and is covered under previous appropriations for EVV compliance.
B) Local governments:
There is no impact on local governments as they neither fund nor provide benefits under the Medicaid program.
C) Small businesses ("small business" means a business employing 1-49 persons)**:**
There is no impact on small businesses as this amendment only clarifies current EVV requirements, and is covered under previous appropriations for EVV compliance.
D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**
There is no impact on non-small businesses as this amendment only clarifies current EVV requirements, and is covered under previous appropriations for EVV compliance.
E) Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***)**:**
There is no impact to other persons or entities as this amendment only clarifies current EVV requirements, and is covered under previous appropriations for EVV compliance.
F) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?)**:**
There are no compliance costs to a single person or entity as this amendment only clarifies current EVV requirements, and is covered under previous appropriations for EVV compliance.
G) Regulatory Impact Summary Table (This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts will be included in narratives above.)

Regulatory Impact Table			
Fiscal Cost	**FY2024**	**FY2025**	**FY2026**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Cost	**$0**	**$0**	**$0**
Fiscal Benefits	**FY2024**	**FY2025**	**FY2026**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Benefits	**$0**	**$0**	**$0**
Net Fiscal Benefits	**$0**	**$0**	**$0**
H) Department head comments on fiscal impact and approval of regulatory impact analysis:			
The Executive Director of the Department of Health and Human Services, Tracy S. Gruber, has reviewed and approved this fiscal analysis. Businesses will see neither costs nor revenue as this amendment only clarifies current EVV requirements, and is covered under previous appropriations for EVV compliance.			

Citation Information

6. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:		
Section 26B-1-213	Section 26B-3-108	

Incorporations by Reference Information

7. Incorporations by Reference (if this rule incorporates more than two items by reference, please include additional tables):	
A) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*):	
Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

B) This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*):	
Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

Public Notice Information

8. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. See Section 63G-3-302 and Rule R15-1 for more information.)		
A) Comments will be accepted until:		10/02/2023
B) A public hearing (optional) will be held:		
Date (mm/dd/yyyy)**:**	**Time** (hh:mm AM/PM)**:**	**Place** (physical address or URL)**:**

To the agency: If more space is needed for a physical address or URL, refer readers to Box 4 in General Information. If more than two hearings will take place, continue to add rows.		

9. This rule change MAY become effective on:	10/09/2023
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 63G-3-302, 63G-3-303, and 63G-3-402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.			
Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	08/09/2023

R414. Health and Human Services, Health Care Financing, Coverage and Reimbursement Policy.
R414-522. Electronic Visit Verification Requirements for Personal Care and Home Health Care Services.
R414-522-1. Introduction and Authority.

This rule implements the electronic visit verification requirements for personal care services and home health care services in accordance with Section 12006 of the 21st Century Cures Act. Electronic visit verification requirements apply to [~~all~~]personal care services or home health care services provided under the Medicaid State Plan or under a Medicaid waiver[~~ of the State Plan~~], which require an in-home visit by a provider. [~~This rule is authorized by~~]Section 26B-[~~18~~]3-[~~3~~]108 authorizes this rule.

R414-522-2. Definitions.

(1) "Electronic visit verification" (EVV) means the use of telephone or computer-based technology to verify the data elements related to the delivery of a Medicaid-covered service.

(2) "EVV system" means the combination of the data collection component and the aggregator component used by a provider to comply with EVV requirements established by the Department.

(3) "Home health care services" (HHCS) means services described in Subsection 1905(a)(7) of the Social Security Act, and provided under the Medicaid State Plan or under a Medicaid 1915(c) waiver[~~ of the State Plan~~].

(4) "Personal care services" (PCS) means personal care services provided under the Medicaid State Plan or under a Medicaid waiver[~~ of the State Plan~~].

(5) "EVV technical specifications means the Department's technical specifications located at https://medicaid.utah.gov/evv/.

R414-522-3. Electronic Visit Verification Requirements.

An EVV record is required for [~~all~~]personal care services (PCS) effective July 1, 2021. An EVV record is required for HHCS effective January 1, 2023.[~~and home health care services effective July 1, 2019.~~] Each PCS and HHCS[~~A~~] provider must select an EVV service vendor and submit EVV records to accompany each PCS or HHCS claim within three months of submitting the claim or payment.[~~have records available for review upon request. While a specific type of software is not mandated,~~] The provider's [~~an~~]EVV system must comply with the [~~provisions of the~~] 21st Century Cures Act, [~~and~~]meet the standards of privacy set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Health Information Technology for Economic and Clinical Health (HITECH) Act[~~.~~], and the EVV technical specifications. The 21st Century Cures Act requires [~~A~~]an EVV data system [~~must~~]to include:

(1) the type of service performed;
(2) the individual receiving the service;
(3) the date of the service;
(4) the location of service delivery;
(5) the individual providing the service;
(6) the time the service begins and ends; and
(7) the date of creation of the electronic record.

R414-522-4. Corrections to Electronic Visit Verification Records.

Guidance on submission of corrected records can be found at https://medicaid.utah.gov/evv/.

R414-522-[4]5. Evaluation of Provider Compliance with Electronic Visit Verification Requirements.

(1) The Department shall conduct annual post-payment reviews of claims requiring EVV for [~~all~~]home health care service and personal care service providers to assess compliance with the requirements.

(2) At random, and for each provider, the Department [~~will~~]selects a calendar month within the previous 12-month period and [~~will~~]includes as part of its audit, [~~all~~]claims for which a provider has service dates and has received reimbursement in the selected month. The Department [~~will~~]also includes in the audit, encounters paid through contracted managed care entities within the selected month.

(3) For any claims and encounters for which an associated EVV record cannot be located, or when the EVV record may not be sufficient to meet the requirements in Section R414-522-3, the Department shall present [~~the findings~~]an audit report to the provider and allow for an opportunity to refute the findings[~~ or request consideration through the fair-hearing process~~].

(4)(a) [~~Claim and encounter disallowances for personal care services, which do not meet EVV requirements, shall become effective January 1, 2020.~~]The Department may issue the provider a corrective action plan and recover funds for claims that do not comply with Section 26B-3-129. Accordingly, the Department may apply the financial penalties established in this subsection.

(b) The Department may withhold payments to a provider that misses deadlines for data submission until the provider submits the required data.

(c) The Department may issue an audit finding to a provider found to have performed PCS or HHCS without submitting EVV records by the required date of compliance. The provider is subject to recoupment of up to 25% of paid amounts for services that require EVV records for the month audited as well as up to the two months before the month audited.

(d) The Department may impose, for a provider that fails to remedy an audit finding, a recoupment of up to 100% of paid amounts for services that require EVV records for the month audited as well as up to the two months before the month audited.

(5) [~~Claim and encounter disallowances for home health care services, which do not meet EVV requirements, shall become effective January 1, 2023.~~]A provider may request an exemption from penalties if the provider makes a good faith effort, but could not implement an EVV solution in time due to circumstances beyond the provider's control. A provider must submit an exemption request to the EVV email within two weeks of being notified of the finding and recoupment. The Department reviews exemption requests and decides within two weeks of receiving the request whether the request meets exemption requirements. Exemption requests are handled on a case-by case basis.

(6) [~~The Department shall recover funds for claims that do not comply with the provisions of Section 26-18-20.~~]A provider may request consideration through the fair hearing process.

KEY: Medicaid
Date of Last Change: July 1, 2019
Authorizing, and Implemented or Interpreted Law: 26B-1-[~~5~~]213; 26B-[~~18~~]3-[~~3~~]108

State of Utah
Administrative Rule Analysis
Revised May 2023

NOTICE OF PROPOSED RULE		
TYPE OF FILING: Amendment		
Title No. - Rule No. - Section No.		
Rule or Section Number:	**R414-515**	**Filing ID: 55693**

Agency Information

1. Department:	Health and Human Services	
Agency:	Health Care Financing, Coverage and Reimbursement Policy	
Building:	Cannon Health Building	
Street address:	288 N. 1460 W.	
City, state and zip:	Salt Lake City, UT 84116	
Mailing address:	PO Box 143102	
City, state and zip:	Salt Lake City, UT 84114-3102	
Contact persons:		
Name:	**Phone:**	**Email:**
Craig Devashrayee	801-538-6641	cdevashrayee@utah.gov
Jonah Shaw	385-310-2389	jshaw@utah.gov
Please address questions regarding information on this notice to the persons listed above.		

General Information

2. Rule or section catchline:
R414-515. Long Term Acute Care.
3. Purpose of the new rule or reason for the change:
The purpose of this change is to update and clarify policy for long-term acute care.
4. Summary of the new rule or change:
This amendment updates and clarifies eligibility, access, coverage, prior authorization, and reimbursement for long-term acute care. It also makes other technical changes.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:
A) State budget:
There is no impact to the state budget as these changes and updates do not affect current appropriations.
B) Local governments:
There is no impact on local governments as they neither fund nor provide benefits under the Medicaid program.
C) Small businesses ("small business" means a business employing 1-49 persons)**:**
There is no impact on small businesses as these changes and updates do not affect current appropriations.
D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**
There is no impact on non-small businesses as these changes and updates do not affect current appropriations.
E) Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***)**:**
There is no impact to other persons or entities as these changes and updates do not affect current appropriations.

F) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?)**:**
There are no compliance costs to a single person or entity as these changes and updates do not affect current appropriations.

G) Regulatory Impact Summary Table (This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts will be included in narratives above.)

Regulatory Impact Table

Fiscal Cost	**FY2024**	**FY2025**	**FY2026**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Cost	**$0**	**$0**	**$0**
Fiscal Benefits	**FY2024**	**FY2025**	**FY2026**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Benefits	**$0**	**$0**	**$0**
Net Fiscal Benefits	**$0**	**$0**	**$0**

H) Department head comments on fiscal impact and approval of regulatory impact analysis:
The Executive Director of the Department of Health and Human Services, Tracy S. Gruber, has reviewed and approved this fiscal analysis. Businesses will see neither costs nor revenue as this amendment only clarifies current EVV requirements, and is covered under previous appropriations for EVV compliance.

Citation Information

6. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:		
Section 26B-1-213	Section 26B-3-108	

Public Notice Information

8. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. See Section 63G-3-302 and Rule R15-1 for more information.)	
A) Comments will be accepted until:	10/16/2023

9. This rule change MAY become effective on:	10/23/2023
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 63G-3-302, 63G-3-303, and 63G-3-402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.			
Agency head or designee and title:	Tracy S. Gruber, Executive Director	**Date:**	08/25/2023

R414. Health and Human Services, Health Care Financing, Coverage and Reimbursement Policy.
R414-515. Long-Term Acute Care.
R414-515-1. [~~Introduction~~]Purpose and Authority.

(1) This rule defines the scope of inpatient long-term acute care (LTAC) hospital [~~(LTAC)~~]services [~~that are~~]available to Medicaid members [~~for the treatment of~~]to treat disorders other than mental disease.

(2) This rule is authorized by Subsection 1886(d)(1)(B)[~~(iv)(I)~~] of the Social Security Act and Sections 26B-1-[~~5~~]213, 26B-[~~18~~]3-[~~2.1~~]102, 26B-[~~18~~]3-[~~2.3~~]104, and 26B-[~~18~~]3-[~~3~~]108.

R414-515-2. Definitions.

(1) "Admission" means the acceptance of a Medicaid member for LTAC [care]and treatment when the member meets established evidence-based criteria for severity of illness and intensity of service and the required service cannot be provided in a lesser level--of--care setting.

(2) "Comprehensive documentation" means applicable, relevant information including a history and physical, operative reports, daily physician progress notes, vital signs, laboratory test results, medications administration records, respiratory therapy notes, wound care notes, nutrition notes, physical therapy notes, occupational therapy notes, speech therapy notes, and [any]other pertinent information the Division of Integrated Healthcare needs to [make a decision regarding the]decide on an LTAC request.

(3) "Continued stay review" means a periodic, supplemental, or interim review of clinical information for an LTAC member.

(4) "Inpatient" means an individual whose severity of illness and intensity of service meet the evidence-based criteria for an LTAC hospital stay.

(5) "Intensity of [S]service" means the measure of the number, technical complexity, or attendant risk of services provided.

(6) ["Long-term acute care hospital" or "Long-term care hospital" (LTAC)]"LTAC" hospital means an inpatient transitional care hospital designed to treat members with multiple, serious medical conditions requiring intense, acute care as determined by a physician.

(7) "Retroactive review" means a review of clinical information for a patient who had previously been admitted to an LTAC hospital, but never received [a]prior authorization for the initial or continued stay due to retroactive eligibility approval.

(8) "Severity of [I]illness" means the extent of a member's organ system derangement or physiologic decompensation[for a patient].

R414-515-3. Client Eligibility Requirements.

[A patient must be eligible for Medicaid services]LTAC hospital services are available to categorically and medically needy individuals.

R414-515-4. Program Access Requirements.

(1)(a) A member must meet the severity of illness and intensity of service for LTAC hospital level--of--care as determined through an evidence-based criteria review process.

([a]b) The Department shall deny an LTAC request for reimbursement if the member does not meet the evidence-based criteria.

[(b) The evidence-based criteria subsets must be utilized correctly (e.g., the primary diagnosis may not additionally be used as a secondary diagnosis).]

(2) The Department may forward LTAC preadmissions, continued stays, and retroactive stays that do not meet the evidence-based criteria [subsets may be forwarded]for secondary medical review if:

(a) the LTAC provider requests the secondary medical review; or

(b) review of documentation shows that LTAC is the most appropriate level--of--care for the member.

R414-515-5. Service Coverage.

(1) A member must receive prior authorization for preadmission, continued stay, and retroactive reviews.

([1]2) An LTAC provider must submit to the Department a request for coverage that includes current and comprehensive documentation, or the Department will return the request as incomplete.

([2]3) The Department shall consider LTAC coverage upon the date it receives the request [and]with current, comprehensive documentation.

([3]4) The Department shall review the documentation to determine preadmission, continued stay, or retroactive stay within three business days of the request.

([4]5) An LTAC provider may not transfer [P]prior authorization [is not transferable from one LTAC]to another LTAC provider.

[(5) Prior authorization is required for preadmission, continued stay, and retroactive reviews.]

(6) If a member transfers from an LTAC hospital to an acute care hospital for any reason, and is away from the LTAC hospital for [greater]more than 24 hours, the LTAC provider shall submit a new preadmission review before transferring the member back to the LTAC hospital.

(7) The Department authorizes [E]each approved prior authorization [is]for [a]up to [seven]28 days[period].

R414-515-6. Preadmission Review.

An LTAC provider shall submit prior authorization requests to the Department at least 24 hours before [the expected]admission. If a member does not admit within 48 hours of approval, the LTAC provider must submit a new prior authorization.

R414-515-7. Continued Stay Review.

An LTAC provider shall submit to the Department continued stay prior authorization requests [to the Department]two days before the end of the approved period. The continued stay prior authorization request must include all pertinent medical record comprehensive documentation supporting the evidence-based LTAC continued stay review.

R414-515-8. Reimbursement Methodology.

The Department authorizes [R]reimbursement for LTAC providers [is]in accordance with the [Utah]Medicaid State Plan.

KEY: Medicaid, long--term acute care, LTAC
Date of Last Change: March 21, 2019
Notice of Continuation: November 30, 2022
Authorizing, and Implemented or Interpreted Law: 26B-1-[5]213; 26B-[18]3-[3]108