

Dear Senators HEIDER, Souza, Jordan, and
Representatives WOOD, Packer, Chew:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of
the Department of Health and Welfare:

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Temporary and Proposed Rule (Docket No.
16-0309-1802);

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Temporary and Proposed Rule (Docket No.
16-0310-1805).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the
cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research
and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative
Services. The final date to call a meeting on the enclosed rules is no later than 07/30/2018. If a meeting is
called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis
from Legislative Services. The final date to hold a meeting on the enclosed rules is 08/27/2018.

The germane joint subcommittee may request a statement of economic impact with respect to a
proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement,
and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has
been held.

To notify Research and Legislation, call 334-4834, or send a written request to the address on the
memorandum attached below.



Eric Milstead
Director

Legislative Services Office

Idaho State Legislature

Serving Idaho's Citizen Legislature

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Health & Welfare Committee and the House Health & Welfare Committee

FROM: Principal Legislative Research Analyst - Elizabeth Bowen

DATE: July 11, 2018

SUBJECT: Department of Health and Welfare

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Temporary and Proposed Rule (Docket No. 16-0309-1802)

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Temporary and Proposed Rule (Docket No. 16-0310-1805)

Summary and Stated Reasons for the Rules

These temporary and proposed rules for the Department of Health and Welfare provide and explain the dental benefits available to Medicaid recipients in order to comply with the provisions of House Bill 465, enacted by the 2018 Legislature. H.B. 465 extended full dental benefits to adult Medicaid recipients on the state's basic plan. Previously, dental benefits for this Medicaid population had been limited to emergency and palliative care.

The Governor finds that temporary adoption of the rules is justified because the rules confer a benefit.

Negotiated Rulemaking / Fiscal Impact

Negotiated rulemaking was not conducted for either rule due to time constraints. The anticipated impact on the state general fund is \$3.8 million.

Statutory Authority

I.C. 56-202

cc: Department of Health and Welfare
Frank Powell and Trinette Middlebrook

*** PLEASE NOTE ***

Per the Idaho Constitution, all administrative rules must be reviewed by the Legislature during the next legislative session. The Legislature has 3 options with this rulemaking docket: **1)** Approve the docket in its entirety; **2)** Reject the docket in its entirety; or **3)** Reject the docket in part.

Kristin Ford, Manager
Research & Legislation

Paul Headlee, Manager
Budget & Policy Analysis

April Renfro, Manager
Legislative Audits

Glenn Harris, Manager
Information Technology

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1802

NOTICE OF RULEMAKING – TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2018.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-264, and 56-1610, Idaho Code, and Titles XIX and XXI of the Social Security Act and Title 56, Chapter 1, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 18, 2018.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Idaho Medicaid was directed during the 2018 session of the Idaho Legislature by passage of House Bill 465 to implement comprehensive dental benefits to all Idaho Medicaid participants.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(a) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons: (a) it is necessary to protect the public health, safety, or welfare; and (c) it confers a benefit.

HB465 was passed during the 2018 legislative session to confer full dental benefits to adults on the Basic Medicaid benefit plan who had previously been limited to palliative and emergency care. This rule change will expand dental benefits to these participants to include the full range of dental benefits available under the Idaho Medicaid program.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year:

There is an expected increase in General Fund expenditures of \$3.8 million. Medicaid will leverage the current Federal matching rate for the Idaho Medicaid program in addition to the anticipated future offset to the general fund of \$2.5 million from a reduction in emergency dental costs and treatment costs for other medical conditions complicated by lack of access to oral health care for these Medicaid participants. The system changes needed for this project are minimal and can be incorporated into existing operations.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because per legislative direction, the effective date for these benefits is July 1, 2018. To meet this time frame, these rules are being submitted as Temporary rules in this Bulletin.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Cindy Brock, (208) 364-1983.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, July 25, 2018.

DATED this 5th day of June, 2018.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500
FAX: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

**THE FOLLOWING IS THE TEMPORARY RULE AND THE PROPOSED TEXT
OF DOCKET NO. 16-0309-1802
(Only Those Sections With Amendments Are Shown.)**

399. COVERED SERVICES UNDER BASIC PLAN BENEFITS.

Individuals who are eligible for Medicaid Basic Plan Benefits are eligible for the following benefits, subject to the coverage limitations contained in these rules. Those individuals eligible for services under IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits,” are also eligible for the services covered under this chapter of rules, unless specifically exempted. (5-8-09)

01. Hospital Services. The range of hospital services covered is described in Sections 400 through 449 of these rules. (5-8-09)

a. Inpatient Hospital Services are described in Sections 400 through 406. (3-30-07)

b. Outpatient Hospital Services are described in Sections 410 through 416. (3-30-07)

c. Reconstructive Surgery services are described in Sections 420 through 426. (3-30-07)

d. Surgical procedures for weight loss are described in Sections 430 through 436. (3-30-07)

e. Investigational procedures or treatments are described in Sections 440 through 446. (3-30-07)

02. Ambulatory Surgical Centers. Ambulatory Surgical Center services are described in Sections 450 through 499 of these rules. (5-8-09)

03. Physician Services and Abortion Procedures. Physician services and abortion procedures are described in Sections 500 through 519 of these rules. (5-8-09)

a. Physician services are described in Sections 500 through 506. (3-30-07)

b. Abortion procedures are described in Sections 510 through 516. (3-30-07)

04. Other Practitioner Services. Other practitioner services are described in Sections 520 through 559 of these rules. (5-8-09)

a. Non-physician practitioner services are described in Sections 520 through 526. (7-1-17)

- b. Chiropractic services are described in Sections 530 through 536. (3-30-07)
- c. Podiatrist services are described in Sections 540 through 545. (3-29-12)
- d. Licensed midwife (LM) services are described in Sections 546 through 552. (3-29-12)
- e. Optometrist services are described in Sections 553 through 556. (3-29-12)
- 05. Primary Care Case Management.** Primary care case management services are described in Sections 560 through 579 of these rules. (5-8-09)
- a. Healthy Connections services are described in Sections 560 through 566. (4-4-13)
- 06. Prevention Services.** The range of prevention services covered is described in Sections 580 through 649 of these rules. (4-4-13)
- a. Child Wellness Services are described in Sections 580 through 586. (3-30-07)
- b. Adult Physical Services are described in Sections 590 through 596. (3-30-07)
- c. Screening mammography services are described in Sections 600 through 606. (3-30-07)
- d. Diagnostic Screening Clinic services are described in Sections 610 through 614. (4-4-13)
- e. Additional Assessment and Evaluation services are described in Section 615. (4-4-13)
- f. Health Questionnaire Assessment is described in Section 618. (4-4-13)
- g. Preventive Health Assistance benefits are described in Sections 620 through 626. (5-8-09)
- h. Nutritional services are described in Sections 630 through 636. (3-30-07)
- i. Diabetes Education and Training services are described in Sections 640 through 646. (3-30-07)
- 07. Laboratory and Radiology Services.** Laboratory and radiology services are described in Sections 650 through 659 of these rules. (5-8-09)
- 08. Prescription Drugs.** Prescription drug services are described in Sections 660 through 679 of these rules. (5-8-09)
- 09. Family Planning.** Family planning services are described in Sections 680 through 689 of these rules. (5-8-09)
- 10. Outpatient Behavioral Health Services.** Community-based outpatient services for behavioral health treatment are described in Sections 707 through 711 of these rules. (3-20-14)
- 11. Inpatient Psychiatric Hospital Services.** Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (3-20-14)
- 12. Home Health Services.** Home health services are described in Sections 720 through 729 of these rules. (5-8-09)
- 13. Therapy Services.** Occupational therapy, physical therapy, and speech-language pathology services are described in Sections 730 through 739 of these rules. (5-8-09)
- 14. Audiology Services.** Audiology services are described in Sections 740 through 749 of these rules. (5-8-09)

- 15. Durable Medical Equipment and Supplies.** The range of covered durable medical equipment and supplies is described in Sections 750 through 779 of these rules. (5-8-09)
- a. Durable Medical Equipment and supplies are described in Sections 750 through 756. (3-30-07)
 - b. Oxygen and related equipment and supplies are described in Sections 760 through 766. (3-30-07)
 - c. Prosthetic and orthotic services are described in Sections 770 through 776. (3-30-07)
- 16. Vision Services.** Vision services are described in Sections 780 through 789 of these rules. (5-8-09)
- 17. Dental Services.** The dental services covered ~~under the Basic Plan~~ by Medicaid are covered under a selective contract as described in Section 800 through 819 of these rules. (~~3-29-12~~)(7-1-18)T
- 18. Essential Providers.** The range of covered essential services is described in Sections 820 through 859 of these rules. (5-8-09)
- a. Rural health clinic services are described in Sections 820 through 826. (3-30-07)
 - b. Federally Qualified Health Center services are described in Sections 830 through 836. (3-30-07)
 - c. Indian Health Services Clinic services are described in Sections 840 through 846. (3-30-07)
 - d. School-Based services are described in Sections 850 through 857. (3-20-14)
- 19. Transportation.** The range of covered transportation services is described in Sections 860 through 879 of these rules. (5-8-09)
- a. Emergency transportation services are described in Sections 860 through 866. (3-30-07)
 - b. Non-emergency medical transportation services are described in Sections 870 through 876. (4-4-13)
- 20. EPSDT Services.** EPSDT services are described in Sections 880 through 889 of these rules. (5-8-09)
- 21. Specific Pregnancy-Related Services.** Specific pregnancy-related services are described in Sections 890 through 899 of these rules. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

SUB AREA: DENTAL SERVICES
(Sections 800 - 819)

800. DENTAL SERVICES: SELECTIVE CONTRACT FOR DENTAL COVERAGE.

All participants ~~who are~~ eligible for Medicaid's ~~Basic Plan~~ dental benefits are covered under a selective contract for a dental insurance program called Idaho Smiles at <http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/DentalServices/tabid/696/Default.aspx>. (~~3-29-12~~)(7-1-18)T

801. DENTAL SERVICES: DEFINITIONS.

For the purposes of dental services covered in Sections 800 through 807 of these rules, the following definitions apply: (3-29-12)

- 01. Adult.** A person who is past the month of his twenty-first birthday. (3-29-12)

02. Child. A person from birth through the month of his twenty-first birthday. (3-29-12)

03. Idaho Smiles. A dental insurance program provided to eligible Medicaid participants through a selective contract between the Department and a dental insurance carrier. (3-29-12)

04. ~~Medicare/Medicaid Coordinated Plan (MMCP).~~ ~~Medical assistance in which Medicaid purchases services from a Medicare Advantage Organization (MAO) and provides other Medicaid-only services covered under the Medicaid Basic Plan in accordance with IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits."~~ (3-29-12)

802. DENTAL SERVICES: PARTICIPANT ELIGIBILITY.

Children, ~~and~~ adults, ~~and pregnant women on Medicaid's Pregnant Woman (PW) Program who meet the eligibility criteria~~ **eligible** for Medicaid's Basic Plan are eligible for Idaho Smiles dental benefits described in Section 803 of these rules. ~~Participants who are over age twenty-one (21), who are eligible for both Medicare A and Medicare B, and who have chosen to enroll in a Medicare/Medicaid Coordinated Plan (MMCP) under IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits," Section 100, receive dental benefits from the MMCP insurance carrier and not from Idaho Smiles.~~ (3-29-12)(7-1-18)T

803. DENTAL SERVICES: COVERAGE AND LIMITATIONS.

Some covered dental services may require authorization from the Idaho Smiles contractor. (3-29-12)

01. Dental Coverage for Children. Children are covered for dental services that include: (3-29-12)

~~a. Preventative and screenings~~ **a.** ~~problem-focused~~ **and comprehensive** exams, diagnostic, restorative, endodontic (**including root canals and crowns**), periodontic, prosthodontic, ~~and~~ orthodontic treatments, dentures, ~~crowns~~ and oral surgery; (3-29-12)(7-1-18)T

~~b. Other dental services that are determined medically necessary by the Department, as required by the Early and Periodic Screening and Diagnostic Testing (EPSDT) guidelines specified in Section 1905(r) of the Social Security Act, are also covered.~~ (3-29-12)

02. Children's Orthodontics Limitations. Orthodontics are limited to children who meet the ~~Basic Plan Medicaid~~ **Medicaid** eligibility requirements, and the Idaho Medicaid Handicapping Malocclusion Index as ~~evaluated determined~~ **evaluated determined** by the state Medicaid dental consultant and the dental insurance ~~State's~~ **State's** contractor's dental consultant. The Malocclusion Index is found in Appendix A of these rules. (3-29-12)(7-1-18)T

03. Dental Coverage and Limitations for Adults. ~~Adults who are not pregnant are limited to the dental services coverage using the Current Dental Terminology (CDT) codes listed in the following table~~ **Adults are covered for dental services that include:**

TABLE 803.03 - ADULT DENTAL SERVICES CODES	
Dental Code	Description
D0140	Limited oral evaluation. Problem focused
D0220	Intraoral periapical film
D0230	Additional intraoral periapical films
D0330	Panoramic film
D7140	Extraction
D7210	Surgical removal of erupted tooth
D7220	Removal of impacted tooth, soft tissue

TABLE 803.03 - ADULT DENTAL SERVICES CODES	
Dental Code	Description
D7230	Removal of impacted tooth, partially bony
D7240	Removal of impacted tooth, completely bony
D7241	Removal of impacted tooth, with complications
D7250	Surgical removal of residual tooth roots
D7260	Oroantral fistula closure
D7261	Primary closure of sinus perforation
D7285	Biopsy of hard oral tissue
D7286	Biopsy of soft oral tissue
D7450	Excision of malignant tumor <1.25 cm
D7451	Excision of malignant tumor >1.25 cm
D7510	Incision and drainage of abscess
D7511	Incision and drainage of abscess, complicated
D9110	Minor palliative treatment of dental pain
D9220	Deep sedation/anesthesia first 30 minutes
D9221	Regional block anesthesia
D9230	Analgesia, anxiolysis, nitrous oxide
D9241	IV conscious sedation first 30 minutes
D9242	IV conscious sedation each additional 15 minutes
D9248	Non IV conscious sedation
D9420	Hospital call
D9610	Therapeutic parenteral drug single administration
D9630	Other drugs and/or medicaments by report

~~(3-29-12)~~(7-1-18)T

a. Preventative screenings, problem-focused and comprehensive exams, diagnostic, restorative, endodontic services with limitations, periodontics, prosthodontic, dentures, and oral surgery. (7-1-18)T

b. Root canals and crowns are not covered. (7-1-18)T

04. Dental Coverage for Pregnant Women. Pregnant women on Medicaid's Basic, Enhanced, or PW plans are covered for preventative and problem focused exams, diagnostic, restorative, endodontic, periodontic, and oral surgery benefits. Specific information about pregnant women is available online at dental services at <http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/DentalServices/tabid/696/Default.aspx>. ~~(3-29-12)~~

054. **Benefit Limitations.** The dental insurance contractor may establish limitations and restrictions for benefits according to the terms of its contract with the Department, in addition to those specified in this rule. ~~(3-29-12)~~(7-1-18)T

804. DENTAL SERVICES: PROCEDURAL REQUIREMENTS.

Providers must enroll in the Idaho Smiles network with the dental insurance contractor and meet both credentialing

and quality assurance guidelines of the contractor. (3-29-12)

01. Administer Idaho Smiles. The contractor is responsible for administering the Idaho Smiles program, including but not limited to dental claims processing, payments to providers, customer service, eligibility verification, and data reporting. (3-29-12)

02. Authorization. The contractor is responsible for authorization of covered dental services that require authorization prior to claim payment. (3-29-12)

03. Grievances. The contractor is responsible for tracking and reporting all grievances to the State's contract monitor. (7-1-18)T

034. ~~Complaints and Appeals.~~ ~~Complaints and a~~ Appeals are handled ~~through~~ by a process between ~~Idaho Smiles~~ the contractor and the Department ~~that is~~ as specified in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," and in compliance with state and federal requirements. (~~3-29-12~~)(7-1-18)T

(BREAK IN CONTINUITY OF SECTIONS)

806. DENTAL SERVICES: PROVIDER REIMBURSEMENT.

The Idaho Smiles administrator reimburses dental providers on a fee-for-service basis under a Department approved fee schedule. The State will collaborate with the contractor to establish rates that promote and ensure adequate access to dental services. (~~3-29-12~~)(7-1-18)T

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1805

NOTICE OF RULEMAKING – TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2018.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-264, and 56-1610, Idaho Code, and Titles XIX and XXI of the Social Security Act and Title 56, Chapter 1, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 18, 2018.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Idaho Medicaid was directed during the 2018 session of the Idaho Legislature by passage of House Bill 465 to implement comprehensive dental benefits to all Idaho Medicaid participants.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(a) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons: (a) it is necessary to protect the public health, safety, or welfare; and (c), conferring a benefit.

HB465 was passed during the 2018 legislative session to confer full dental benefits to adults on the Basic Medicaid benefit plan who had previously been limited to palliative and emergency care. This rule change will expand dental benefits to these participants to include the full range of dental benefits available under the Idaho Medicaid program.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year:

There is an expected increase in General Fund expenditures of \$3.8 million. Medicaid will leverage the current Federal matching rate for the Idaho Medicaid program in addition to the anticipated future offset to the general fund of \$2.5 million from a reduction in emergency dental costs and treatment costs for other medical conditions complicated by lack of access to oral health care for these Medicaid participants. The system changes needed for this project are minimal and can be incorporated into existing operations.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because per legislative direction, the effective date for these benefits is July 1, 2018. To meet this time frame, these rules are being submitted as Temporary rules in this Bulletin.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Cindy Brock, (208) 364-1983.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, July 25, 2018.

DATED this 5th day of June, 2018.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500
FAX: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

**THE FOLLOWING IS THE TEMPORARY RULE AND THE PROPOSED TEXT
OF DOCKET NO. 16-0310-1805
(Only Those Sections With Amendments Are Shown.)**

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits.” (3-19-07)

02. Scope. These rules establish the Medicaid Enhanced Plan Benefits covered under Title XIX and Title XXI. Participants who are eligible for Enhanced Plan Benefits are also eligible for benefits under IDAPA 16.03.09, “Medicaid Basic Plan Benefits.” ~~Dental services for the Medicaid Enhanced Plan are covered under Sections 080 through 087 of these rules.~~ ~~Dental benefits and~~ outpatient behavioral health benefits are contained in IDAPA 16.03.09. “Medicaid Basic Plan Benefits.” (4-11-15)(7-1-18)T

03. Scope of Reimbursement System Audits. These rules also provide for the audit of providers’ claimed costs against these rules and Medicare standards. The Department reserves the right to audit financial and other records of the provider, and, when warranted, the records of entities related to the provider. Audits consist of the following types of records: (3-19-07)

- a.** Cost verification of actual costs for providing goods and services; (3-19-07)
- b.** Evaluation of provider’s compliance with the provider agreement, reporting form instructions, and any applicable law, rule, or regulation; (3-19-07)
- c.** Effectiveness of the service to achieve desired results or benefits; and (3-19-07)
- d.** Reimbursement rates or settlement calculated under this chapter. (3-19-07)

04. Exception to Scope for Audits and Investigations. Audits as described in these rules do not apply to the audit processes used in conducting investigations of fraud and abuse under IDAPA 16.05.07, “Investigation and Enforcement of Fraud, Abuse, and Misconduct.” (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

075. ENHANCED PLAN BENEFITS: COVERED SERVICES.

Individuals who are eligible for the Medicaid Enhanced Plan Benefits are eligible for all benefits covered under IDAPA 16.03.09, “Medicaid Basic Plan Benefits.” In addition to those benefits, individuals in the enhanced plan are eligible for the following enhanced benefits as provided for in this chapter of rules. (4-11-15)

- 01. Dental Services.** Dental Services are ~~provided as~~ described ~~under Sections 080 through 089 of these rules~~ in IDAPA 16.03.09, “Medicaid Basic Plan Benefits.” ~~(3-29-12)(7-1-18)T~~
- 02. Enhanced Hospital Benefits.** Organ transplants are provided under the Enhanced Hospital services as described in Sections 090 through 099 of these rules. (3-19-07)
- 03. Enhanced Outpatient Behavioral Health Benefits.** Enhanced Outpatient Behavioral Health services are described in IDAPA 16.03.09, “Medicaid Basic Plan Benefits.” (3-20-14)
- 04. Enhanced Home Health Benefits.** Private Duty Nursing services are provided under the Enhanced Home Health as described in Sections 200-219 of these rules. (3-19-07)
- 05. Therapies.** Physical, Speech, and Occupational Therapy Providers as described in Section 215 of these rules. (3-19-07)
- 06. Long Term Care Services.** The following services are provided under the Long Term Care Services. (3-30-07)
- a.** Nursing Facility Services as described in Sections 220 through 299 of these rules. (3-19-07)
 - b.** Personal Care Services as described in Sections 300 through 308 of these rules. (3-30-07)
 - c.** A & D Wavier Services as described in Sections 320 through 330 of these rules. (3-30-07)
- 07. Hospice.** Hospice services as described in Sections 450 through 459 of these rules. (3-19-07)
- 08. Developmental Disabilities Services.** (3-19-07)
- a.** Children’s Developmental Disability Services as described in Sections 520 through 528, 660 through 666, and 680 through 686 of these rules. (7-1-13)
 - b.** Adult Developmental Disabilities Services as described in Sections 507 through 519, 645 through 657, and 700 through 706 of these rules. (7-1-16)
 - c.** ICF/ID as described in Sections 580 through 649 of these rules. (3-19-07)
- 09. Service Coordination Services.** Service coordination as described in 720 through 779 of these rules. (3-19-07)
- 10. Breast and Cervical Cancer Program.** Breast and Cervical Cancer Program is described in Sections 780 through 800 of these rules. (3-19-07)

076. -- 0789. (RESERVED)

~~080. DENTAL SERVICES: SELECTIVE CONTRACT FOR DENTAL COVERAGE.~~

~~All participants who are eligible for Medicaid’s Enhanced Plan dental benefits are covered under a selective contract for a dental insurance program called Idaho Smiles at <http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/DentalServices/tabid/696/Default.aspx>.~~ (3-29-12)

~~081. DENTAL SERVICES: DEFINITIONS.~~

~~For the purposes of dental services covered in Sections 080 through 087 of these rules, the following definitions apply:~~ (3-29-12)

- ~~**01. Adult.** A person who is past the month of his twenty-first birthday. (3-29-12)~~
- ~~**02. Child.** A person from birth through the month of his twenty-first birthday. (3-29-12)~~

~~03. **Idaho Smiles.** A dental insurance program provided to eligible Medicaid participants through a selective contract between the Department and a dental insurance carrier. (3-29-12)~~

~~082. **DENTAL SERVICES: PARTICIPANT ELIGIBILITY.**~~

~~All children and adults participating in Medicaid's Enhanced Plan are eligible for Idaho Smiles dental benefits described in Section 083 of these rules. (4-11-15)~~

~~083. **DENTAL SERVICES: COVERAGE AND LIMITATIONS.**~~

~~Some covered dental services may require authorization from the Idaho Smiles contractor. (3-29-12)~~

~~01. **Dental Coverage for Children.** Children are covered for dental services that include: (3-29-12)~~

~~a. Medically necessary preventive and problem focused exams, diagnostic and restorative services, treatment for conditions of the gums and dental pulp, braces and other orthodontic treatments, dentures, crowns, and oral surgery; and (4-11-15)~~

~~b. Other dental services as required by the Early and Periodic Screening and Diagnostic Testing (EPSDT) guidelines specified in Section 1905(r) of the Social Security Act. (4-11-15)~~

~~02. **Children's Orthodontics Limitations.** Orthodontics are limited to children who meet the Enhanced Plan eligibility requirements, and the Idaho Medicaid Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant and the dental insurance contractor's dental consultant. The Malocclusion Index is found in Appendix A of these rules. (3-29-12)~~

~~03. **Dental Coverage for Adults.** Adults are covered for medically necessary preventive and problem-focused exams, diagnostic and restorative services, treatment for conditions of the gums and dental pulp, dentures, oral surgery, and adjunctive dental services within the limits of coverage established by the Department. (4-11-15)~~

~~04. **Benefit Limitations.** The dental insurance contractor may establish limitations and restrictions for benefits according to the terms of its contract with the Department. (3-29-12)~~

~~084. **DENTAL SERVICES: PROCEDURAL REQUIREMENTS.**~~

~~Providers must enroll in the Idaho Smiles network with the dental insurance contractor and meet both credentialing and quality assurance guidelines of the contractor. (3-29-12)~~

~~01. **Administer Idaho Smiles.** The contractor is responsible for administering the Idaho Smiles program, including but not limited to dental claims processing, payments to providers, customer service, eligibility verification, and data reporting. (3-29-12)~~

~~02. **Authorization.** The contractor is responsible for authorization of covered dental services that require authorization prior to claim payment. (3-29-12)~~

~~03. **Complaints and Appeals.** Complaints and appeals are handled through a process between Idaho Smiles and the Department that is in compliance with state and federal requirements. (3-29-12)~~

~~085. **DENTAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.**~~

~~Providers are credentialed by the contractor to ensure they meet licensing requirements of the Idaho Board of Dentistry standards. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. (3-29-12)~~

~~086. **DENTAL SERVICES: PROVIDER REIMBURSEMENT.**~~

~~The Idaho Smiles administrator reimburses dental providers on a fee-for-service basis under a Department approved fee schedule. (3-29-12)~~

~~087. **DENTAL SERVICES: QUALITY ASSURANCE.**~~

~~Providers are subject to the contractor's Quality Assurance guidelines including monitoring for potential fraud,~~

~~overutilization, or abuse of Medicaid. The contractor is required to share such potential cases with the Medicaid Fraud Unit as discovered.~~ (3-29-12)

~~088. -- 089.~~ (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

624. ICF/ID: CAPPED COST.

Beginning October 1, 1996, this cost area includes all allowable costs except those specifically identified as property costs in Section 623 of these rules and exempt costs or excluded costs in Section 627 or 628 of these rules. This Section defines items and procedures to be followed in determining allowable and exempt costs and provides the procedures for extracting cost data from historical cost reports, applying a cost forecasting market basket to project cost forward, procedures to be followed to project costs forward, and procedures for computing the median of the range of costs and the ICF/ID cap. (3-19-07)

01. Costs Subject to the Cap. Items subject to the cap include all allowable costs except property costs identified in Section 623 of these rules and exempt costs or excluded costs identified in Section 627 or 628 of these rules. Property costs related to a home office are administrative costs, will not be reported as property costs, and are subject to the cap. (3-19-07)

02. Per Diem Costs. Costs to be included in this category will be divided by the total participant days for the facility for the cost reporting period to arrive at allowable per diem costs. If costs for services provided some or all non-Medicaid residents are not included in the total costs submitted, the provider must determine the costs and combine them with the submitted costs in order that a total per diem cost for that facility can be determined both for both the purposes of determining the ICF/ID cap and of computing final reimbursement. (3-19-07)

03. Cost Data to Determine the Cap. Cost data to be used to determine the cap for ICF/ID facilities will be taken from each provider's most recent final cost report available sixty (60) days before the beginning of the period for which the cap is being set. Cost reports are final when the final audit report is issued, or earlier if the Department informs the facility the report is final for rate setting purposes. The selected final cost report will be used to establish the facility's prospective reimbursement rate. However, the final cost reports covering a period of less than twelve (12) months will be included in the data for determining the cap at the option of the Department. (3-19-07)

04. Projection. Per diem allowable costs will be inflated forward using a cost forecasting market basket and forecasting indices according to the same table as used for free standing facilities. (3-19-07)

a. The projection method used in Section 624 of these rules to set the cap will also be used to set non property portions of the prospective rate that are not subject to the cap. (3-19-07)

b. Forecasting indices as developed by Data Resources, Incorporated, will be used unless they are unavailable. In such case, indices supplied by some other nationally recognized forecaster will be used. (3-19-07)

05. Costs That Can be Paid Directly by the Department to Non ICF/ID Providers. Costs that can be paid directly by the Department to non ICF/ID providers are excluded from the ICF/ID prospective rates and ICF/ID cap: (3-19-07)

a. Direct physician care costs. Physicians who provide these services must bill the Medicaid program directly using their own provider numbers. (3-19-07)

b. Costs of services covered under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) portion of the Medicaid Program. Items such as eyeglasses and hearing aids are covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ~~Dental services provided to EPSDT participants who are under the age of twenty-one (21) and who reside in an ICF/ID, are covered under Sections 080 through 085 of these rules.~~ The cost of these services is not includable as a part of ICF/ID costs. Reimbursement can be made to a professional providing

these services through his billing the Medicaid Program on his own provider number.

~~(5-8-09)~~(7-1-18)T

c. Costs of services covered by other parts of the Medicaid Program. Examples of these items include legend drugs and ambulance transportation. These items must be billed to the Medicaid Program directly by the provider using his own provider number. (3-19-07)

06. Cost Projection. Allowable per diem costs will be projected forward from the midpoint of the Base Period to the midpoint of the Target Period. “Base Period” is defined as the last available final cost report period. “Target Period” is defined as the effective period of the prospective rate. Procedures for inflating these costs are as follows: (3-19-07)

a. The percentage change for each cost category in the market basket will be computed from the beginning to the end of the Base Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward allowable per diem costs for each cost category from the midpoint to the end of the Base Period. (3-19-07)

b. The percentage change for each cost category in the market basket will be computed for the period from the end of the Base Period to the beginning of the Target Period. These percentages will then be used to project forward the allowable per diem costs for each cost category, as determined in Subsection 624.06.a. of these rules, from the end of the Base Period to the beginning of the Target Period. (3-19-07)

c. The percentage change for each cost category in the market basket will be computed for the beginning to the end of the Target Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward the allowable per diem costs as determined in Subsection 624.06.b. of these rules from the beginning to the midpoint of the Target Period. (3-19-07)

07. Cost Ranking. Prior to October 1st of each year the Director will determine the that percent above the median that will assure aggregate payments to ICF/ID providers will approximate but not exceed amounts that would be incurred using Medicare cost principles of reimbursement. That percentage will apply to caps and rates set after September 30th of each year. Projected per diem costs as determined in this section and subject to the cap will be ranked from the highest to the lowest. The cap will be set at a percent of the bed-weighted median for each rate period. The initial cap will be set as of October 1, 1996. (3-19-07)

a. The median of the range will be computed based on the available data points being considered as the total population of data points. (3-19-07)

b. The cap for each ICF/ID facility with a fiscal year beginning October 1, 1996, will be computed prior to the beginning of that year. For those facilities with a fiscal year ending on a date other than September 30th, the first cap will be computed for the period beginning October 1, 1996, and ending on the fiscal year end date. (3-19-07)

c. Facilities with cost reports that transcend the period from October 1, 1996, through September 30, 1997, will be retrospectively settled using the previous reimbursement system for the period of the report up to September 30, 1996. There will not be a retrospective settlement on the portion of these cost reports attributed to October 1, 1996 through the end of the cost report period unless provisions of Section 626 of these rules apply. (3-19-07)

d. Cost reports for periods beginning on or after October 1, 1996, will not be subject to retrospective settlement except as required by other provisions of this chapter. (3-19-07)

e. A new cap and rate will be set on an annual basis for each facility the first of July every year. (3-19-07)

f. The cap and prospective rate will be determined and set on an annual basis for each facility July first of every year and will not be changed by any subsequent events or information with the exception that if the computations were found to contain mathematical or clerical errors, these errors will be corrected and the cap will be adjusted using the corrected figures. (3-19-07)

g. Payment of costs subject to the cap will be limited to the cap unless the Department determines the exclusions found in Section 628 of these rules apply. (3-19-07)

h. A facility that commences to offer participant care services as an ICF/ID on or after October 1, 1996, will be subject to retrospective settlement until the first prospective rate is set. Such facility will be subject to the ICF/ID cap as determined in this chapter. The first prospective rate for this provider will be set by the Department based on quarterly cost statements and final cost reports submitted for periods following the first three (3) months of operation. This first prospective rate may be set after the beginning of the second fiscal year of the provider. For the second year the provider will be paid a rate to be settled retrospectively unless both the Department and the provider agree to a prospective rate or rates covering that fiscal period. (3-19-07)