

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 - Proposed Rule (Docket No. 16-0309-1702);

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Proposed Rule (Docket No. 16-0309-1703);

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Proposed Rule (Docket No. 16-0309-1704);

IDAPA 16.03.18 - Medicaid Cost-Sharing (Fee Rule) - Proposed Rule (Docket No. 16-0318-1701).

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 11/09/2017. 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 12/11/2017.

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: Senior Legislative Research Analyst - Elizabeth Bowen

DATE: October 23, 2017

SUBJECT: Department of Health and Welfare

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Proposed Rule (Docket No. 16-0309-1702)

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Proposed Rule (Docket No. 16-0309-1703)

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Proposed Rule (Docket No. 16-0309-1704)

IDAPA 16.03.18 - Medicaid Cost-Sharing (Fee Rule) - Proposed Rule (Docket No. 16-0318-1701)

The Department of Health and Welfare submits notice of proposed rulemaking at IDAPA 16.03.09 (three dockets) and 16.03.18.

16.03.09 - Docket No. 16-0309-1702

This rule, regarding Medicaid Basic Plan benefits, revises existing rules to conform to federal regulations providing that access to mental health care services cannot be more restrictive than access for medical or surgical services. Negotiated rulemaking was conducted, and there is no anticipated negative fiscal impact on the state general fund. The Department states that this rulemaking is authorized pursuant to several sections of the Idaho Code, including Section 56-202, which authorizes rulemaking for public assistance programs.

16.03.09 - Docket No. 16-0309-1703

This rule, regarding Medicaid Basic Plan benefits, is intended to streamline program processes in order to improve patient access to early intervention services. Negotiated rulemaking was conducted, and there is no anticipated negative fiscal impact on the state general fund. The Department states that this rulemaking is authorized pursuant to several sections of the Idaho Code, including Section 56-202, which authorizes rulemaking for public assistance programs.

16.03.09 - Docket No. 16-0309-1704

This rule, regarding Medicaid Basic Plan benefits, removes reference to an eligibility assessment tool that will no longer be used pursuant to a settlement agreement. Negotiated rulemaking was not conducted due to the nature of the rule change, which is to comply with the settlement agreement. There is no further anticipated negative fiscal impact to the state general fund; prior appropriation to implement a new assessment tool was made by the 2017 Legislature. The Department states that this rulemaking is authorized pursuant to

several sections of the Idaho Code, including Section 56-202, which authorizes rulemaking for public assistance programs.

16.03.18

This rule, regarding Medicaid cost-sharing, provides that participants in the Youth Empowerment Services program shall be charged a premium based on family income. Negotiated rulemaking was conducted. The cost-sharing is anticipated to offset costs to the state general fund by \$57,000 in fiscal year 2019. The Department states that this rulemaking is authorized pursuant to several sections of the Idaho Code, including Section 56-202, which authorizes rulemaking for public assistance programs.

cc: Department of Health and Welfare
Beverly Barr and Frank Powell

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1702

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, and 42 CFR Sections 438, 440, and 457.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

PUBLIC HEARING

Friday, October 13, 2017 — 2:00 p.m. (Local)

**Central Idaho - DHW Office
3232 Elder Street
Conference Room D - East
Boise, ID 83705**

TELECONFERENCE CALL-IN

**Toll Free: 1-877-820-7831
Participant Code: 701700**

The hearing site 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 a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under the CFR sections cited above, access to mental healthcare services cannot be more restrictive than access for medical/surgical services. These rule changes allow the Department flexibility to adjust requirements for authorizations and coverage to ensure that access to mental health services is consistent with the requirements in CFR.

Specifically, inpatient psychiatric stays will be permitted for as long as they are medically necessary, and will be subject to the same reviews as general hospital stays. Participant eligibility for inpatient psychiatric stays are being defined to align with CFR restrictions. General hospital procedural guidelines are being changed to provide a psychiatric services structure with which to align. General hospital inpatient provisions are being changed to match current Medicaid practice and Centers for Medicare and Medicaid Services (CMS) requirements. Finally, under physician services, limitations for psychiatric evaluations and psychotherapy are being removed. Should the Department need to make adjustments to remain in compliance with federal requirements or to maintain appropriate utilization of services in the future, these changes will allow for modification for those needs.

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 as a result of this rulemaking:

The fiscal impact associated with this rule change is minimal to none. An analysis conducted by the Division of Medicaid concluded any potential impact is so minimal that requesting additional funds is not warranted at this time.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 7, 2017, Idaho Administrative Bulletin, **Vol. 17-6, pages 36 and 37.**

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact William Deseron at (208) 364-1967.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2017.

DATED this 1st day of September, 2017

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500
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THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0309-1702
(Only Those Sections With Amendments Are Shown.)

402. INPATIENT HOSPITAL SERVICES: COVERAGE AND LIMITATIONS.

The policy, rules, and regulations to be followed will be those cited in 42 CFR 456.50 through 42 CFR 456.145. All hospital services must conform to federal and state laws and regulations. Services must be medically necessary as defined in Section 011 of these rules. (3-30-07)()

01. Initial Length of Stay. Prior authorization requirement for an initial length of stay will be established by the Department, or its designee, in the Idaho Medicaid Provider Handbook. ()

02. Extended Stay. The Department, or its designee, will establish authorization requirements in the Idaho Medicaid Provider Handbook. An authorization is necessary when the appropriate care of the participant indicates the need for hospital days in excess of the initial length of stay, or previously approved extended stay. ()

~~03.~~ **Exceptions and Limitations.** The following exceptions and limitations apply to in-patient hospital services: (3-30-07)

a. Payment for accommodations is limited to the hospital's all-inclusive rate. The all-inclusive rate is a flat fee charge incurred on a daily basis that covers both room and board. (3-30-07)

b. The Department must not authorize reimbursement above the all-inclusive rate unless the attending physician orders a room that is not an all-inclusive rate room for the patient because of medical necessity. (3-30-07)

~~02. Limitation of Administratively Necessary Days (ANDs). Each participant is limited to no more~~

~~than three (3) ANDs per discharge. In the event that a nursing facility level of care is required, an AND may be authorized provided that the hospital documents that no nursing facility bed is available within twenty five (25) miles of the hospital.~~ (3-30-07)

403. INPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. Prior Authorization. Some services may require a prior authorization from the Department or its designee. Documentation for the request must include the most recent plan of care and adequate documentation to demonstrate continued medical necessity. The Department will set additional documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. ()

02. Certification of Need. At the time of admission, the physician must certify that inpatient services are necessary. Recertification must occur at least every sixty (60) days inpatient hospital services are required, but may be required more frequently as determined by the Department. ()

03. Individual Plan of Care. The individual plan of care is a written plan developed for the participant upon admission to a hospital and updated at least every sixty (60) days, but may be required more frequently as determined by the Department. The plan must include: ()

a. Diagnoses, symptoms, complaints, and complications indicating the need for admission; ()

b. A description of the functional level of the individual; ()

c. Any orders for medications, treatments, rehabilitative services, activities, social services, or diet; and ()

d. Plans for continuing care or discharge, as appropriate. ()

04. Request for Extended Stay. To qualify for reimbursement, authorization must be obtained from the Department, or its designee. The request should be made before the initial length of stay or previously authorized extended stay ends, and submitted as designated by the Department, or its designee. Documentation for the request should include the most recent plan of care. The Department will set additional documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. ()

05. Administratively Necessary Day Requests (AND). When Administratively Necessary Days are requested, the hospital must provide the Department with complete and timely documentation prior to the participant's anticipated discharge date ~~in order to be considered~~. Authorization for reimbursement will be denied for all untimely requests and tardy submittal of requested documentation. All requests for AND must be made in writing ~~or by telephone~~. Hospitals must make the documentation and related information requested by the Department available within ten (10) working days of the date of the request ~~in order~~ for subsequent payment to be granted. The documentation provided by the hospital will include, but is not limited to: (3-30-07)()

~~01a.~~ A Brief Summary. A brief summary of the participant's medical condition; and (3-30-07)

~~02b.~~ Statements. Statements as to why the participant ~~cannot receive the necessary medical services in is unable to discharge to~~ a nonhospital setting; and (3-30-07)()

~~03c.~~ Documentation. Documentation that the hospital has diligently made every effort to locate, without success, a facility or organization within twenty-five (25) miles which is able and willing to deliver the appropriate care. Such evidence must include a list of facilities and organizations, the dates of contact, the names of the persons contacted, and the result of each contact. (3-30-07)()

(BREAK IN CONTINUITY OF SECTIONS)

405. INPATIENT HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.

Under the Medicaid provisions of the Social Security Act, in reimbursing hospitals, the Department will pay the lesser of customary hospital charges or the reasonable cost of inpatient services in accordance with the procedures detailed under this Section of rule. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment that would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement. (3-30-07)

01. Exemption of New Hospitals. A hospital that has operated as the type of facility for which it is certified (or the equivalent thereof) under present and previous ownership for less than three (3) full years will be paid in accordance with the Title XVIII principles of reasonable cost reimbursement, including those provisions applicable to new providers for the carryover and recovery of unreimbursed costs, in accordance with 42 CFR Section 413.64. (3-30-07)

02. Medicaid Inpatient Operating Cost Limits. The following describe the determination of inpatient operating cost limits. (3-30-07)

a. Medicaid Cost Limits for Dates of Service Prior to a Current Year. The reimbursable reasonable costs for services rendered prior to the beginning of the principal year, but included as prior period claims in a subsequent period's cost report, will be subject to the same operating cost limits as the claims under settlement. (3-30-07)

b. Application of the Medicaid Cost Limit. In the determination of a hospital's reasonable costs for inpatient services rendered after the effective date of a principal year, a $H_{\text{hospital}} I_{\text{inflation}} I_{\text{index}}$, computed for each hospital's fiscal year end, will be applied to the operating costs, excluding capital costs and other allowable costs as defined for the principal year and adjusted on a per diem basis for each subsequent year under the $H_{\text{hospital}} I_{\text{inflation}} I_{\text{index}}$. (3-30-07)()

i. Each inpatient routine service cost center, as reported in the finalized principal year end Medicare cost report, will be segregated in the Medicaid cost limit calculation and assigned a share of total Medicaid inpatient ancillary costs. The prorated ancillary costs will be determined by the ratio of each Medicaid routine cost center's reported costs to total Medicaid inpatient routine service costs in the principal year. (3-30-07)

ii. Each routine cost center's total Medicaid routine service costs plus the assigned share of Medicaid inpatient ancillary costs of the principal year will be divided by the related Medicaid patient days to identify the total costs per diem in the principal year. (3-30-07)

(1) The related inpatient routine service cost center's per diem capital and graduate medical education costs plus the prorated share of inpatient ancillary capital costs will be subtracted from the per diem amount identified in Subsection 405.02.b.ii. of this rule to identify each inpatient routine service cost center per diem cost limit in the principal year. (3-30-07)

(2) If a provider did not have any Medicaid inpatient utilization or render any Medicaid inpatient services in an individual inpatient routine service cost center in the fiscal year serving as the principal year, the principal year for only those routine cost centers without utilization in the provider's principal year will be appropriately calculated using the information available in the next subsequent year in which Medicaid utilization occurred. (3-30-07)

iii. Each routine cost center's cost per diem for the principal year will be multiplied by the $H_{\text{hospital}} I_{\text{inflation}} I_{\text{index}}$ for each subsequent fiscal year. (3-30-07)()

iv. The sum of the per diem cost limits for the Medicaid inpatient routine service cost centers of a hospital during the principal year, as adjusted by the $H_{\text{hospital}} I_{\text{inflation}} I_{\text{index}}$, will be the Medicaid cost limit for operating costs in the current year. (3-30-07)()

(1) At the date of final settlement, reimbursement of the Medicaid current year inpatient routine cost centers plus the assigned ancillary costs will be limited to the total per diem operating costs as adjusted for each subsequent fiscal year after the principal year through the current year by the $H_{\text{hospital}} I_{\text{inflation}} I_{\text{index}}$. (3-30-07)()

(2) Providers will be notified of the estimated inflation index periodically or ~~H~~hospital ~~I~~inflation ~~I~~index (CMS Market Basket Index) prior to final settlement only upon written request. (3-30-07)()

03. Adjustments to the Medicaid Cost Limit. A hospital's request for review by the Department concerning an adjustment to or exemption from the cost limits imposed under the provisions set forth in Section 405 of this chapter of rules, must be granted under the following circumstances: (3-30-07)

a. Adjustments. Because of Extraordinary Circumstances. Where a provider's costs exceed the Medicaid limit due to extraordinary circumstances beyond the control of the provider, the provider can request an adjustment to the cost limit to the extent the provider proves such higher costs result from the extraordinary circumstances including, but not limited to, increased costs attributable to strikes, fires, earthquake, flood, or similar, unusual occurrences with substantial cost effects. (3-30-07)

b. Reimbursement to Public Hospitals. A ~~P~~ublic ~~H~~ospital that provides services free or at a nominal charge, which is less than, or equal to fifty percent (50%) of its total allowable costs, will be reimbursed at the same rate that would be used if the hospital's charges were equal to, or greater than, its costs. (3-30-07)()

c. Adjustment to Cost Limits. A hospital is entitled to a reasonable increase in its Medicaid ~~C~~ost limits if the hospital shows that its per diem costs of providing services have increased due to increases in case- mix, the adoption of new or changed services, the discontinuation of services or decrease in average length of stay for Medicaid inpatients since the principal year. Any hospital making such showing is entitled to an increase commensurate with the increase in per diem costs. (3-30-07)()

i. The Medicaid operating cost limit may be adjusted by multiplying cost limit by the ratio of the current year's ~~C~~ase-~~M~~ix ~~I~~ndex divided by the principal year's ~~C~~ase-~~M~~ix ~~I~~ndex. (3-30-07)()

ii. The contested case procedure set ~~for~~ forth in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," is available to larger hospitals seeking such adjustments to their Medicaid ~~C~~ost ~~L~~imits. (3-30-07)()

d. Adjustment to the Proration of Ancillary Costs in the principal year. Where the provider asserts that the proration of ancillary costs does not adequately reflect the total Medicaid cost per diem calculated for the inpatient routine service cost centers in the principal year, the provider may submit a detailed analysis of ancillary services provided to each participant for each type of patient day during each participant's stay during the principal year. The provider will be granted this adjustment only once upon appeal for the first cost reporting year that the limits are in effect. (3-30-07)

04. Payment Procedures. The following procedures are applicable to in-patient hospitals: (3-30-07)

a. The participant's admission and length of stay is subject to ~~preadmission~~ ~~prior~~ ~~authorization~~, concurrent ~~review~~, ~~continued stay review~~, and retrospective review by a Quality Improvement Organization (QIO) designated by the Department. QIO review will be governed by provisions of the QIO Idaho Medicaid Provider Manual as amended. If ~~such a~~ review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. Failure to obtain a timely QIO review as required by Section 405~~2~~ of this chapter of rules, and as outlined in the QIO Idaho Medicaid Provider Manual as amended, will result in the QIO conducting a late review. After a QIO review has determined that the hospital stay was medically necessary, Medicaid will assess a late review penalty to the hospital as outlined in ~~Sub~~section 405-~~05~~ of this rule. (3-30-07)()

i. All admissions are subject to QIO review to determine if continued stay in inpatient status is medically necessary. A QIO continued stay review is required when the participant's length of stay exceeds the number of days certified by the QIO. If no initial length of stay certification was issued by the QIO, a QIO continued stay review is required when the admission exceeds a number of days as specified by the Department. (3-30-07)

ii. Reimbursement for services originally identified as not medically necessary by the QIO will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-30-07)

iii. Absent the Medicaid participant's informed decision to incur services deemed unnecessary by the QIO, or not authorized by the QIO due to the negligence of the provider, no payment for denied services may be obtained from the participant. (3-30-07)

b. In reimbursing licensed hospitals, the Department will pay the lesser of customary hospital charges or the reasonable cost of semi-private rates for in-patient hospital care as set forth in this rule, unless an exception applies as stated in Section 402 of these rules. The upper limits for payment must not exceed the payment which would be determined as reasonable cost using the Title XVIII standards and principles. (3-30-07)

05. Hospital Penalty Schedule. (3-30-07)

a. A request for a preadmission and/or continued stay QIO review that is one (1) day late will result in a penalty of two hundred and sixty dollars (\$260), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

b. A request for a preadmission and/or continued stay QIO review that is two (2) days late will result in a penalty of five hundred and twenty dollars (\$520), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

c. A request for a preadmission and/or continued stay QIO review that is three (3) days late will result in a penalty of seven hundred and eighty dollars (\$780), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

d. A request for a preadmission and/or continued stay QIO review that is four (4) days late will result in a penalty of one thousand and forty dollars (\$1,040), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

e. A request for a preadmission and/or continued stay QIO review that is five (5) days late or greater will result in a penalty of one thousand three hundred dollars (\$1,300), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

06. AND Reimbursement Rate. Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho nursing facilities for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. ICF/ID rates are excluded from this calculation. (3-30-07)

a. The AND reimbursement rate will be calculated by the Department by March 15 of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year. (3-30-07)

b. Hospitals with an attached nursing facility will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and (3-30-07)

c. The Department will pay the lesser of the established AND rate or a facility's customary hospital charge to private pay patients for an AND. (3-30-07)

07. Reimbursement for Services. Routine services as addressed in Subsection 405.08 of this rule include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in these rules. Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (3-30-07)

08. Hospital Swing-Bed Reimbursement. The Department will pay for nursing facility care in certain rural hospitals. Following approval by the Department, such hospitals may provide service to participants in licensed hospital ("swing") beds who require nursing facility level of care. (3-30-07)

a. Facility Requirements. The Department will approve hospitals for nursing facility care provided to

eligible participants under the following conditions: (3-30-07)

i. The Department’s Licensure and Certification Section finds the hospital in conformance with the requirements of 42 CFR 482.58 “Special Requirements” for hospital providers of long-term care services (“swingbeds”); and (3-30-07)

ii. The hospital is approved by the Medicare program for the provision of “swing-bed” services; and (3-30-07)

and iii. The facility does not have a twenty-four (24) hour nursing waiver granted under 42 CFR 488.54(c); (3-30-07)

iv. The hospital must not have had a swing-bed approval terminated within the two (2) years previous to application for swing-bed participation; and (3-30-07)

v. The hospital must be licensed for less than one hundred (100) beds as defined by 42 CFR 482.58(a)(1) for swing-bed purposes; and (3-30-07)

vi. Nursing facility services in swing-beds must be rendered in beds used interchangeably to furnish hospital or nursing facility-type services. (3-30-07)

b. Participant Requirements. The Department will reimburse hospitals for participants under the following conditions: (3-30-07)

i. The participant is determined to be entitled to such services in accordance with IDAPA 16.03.05, “Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled”; and (3-30-07)

ii. The participant is authorized for payment in accordance with IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits,” Subsection 222.02. (3-30-07)

c. Reimbursement for “Swing-Bed” Patient Days. The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: (3-30-07)

i. Payment rates for routine nursing facility services will be at the weighted average Medicaid rate per patient day paid to hospital-based nursing facility/ICF facilities for routine services furnished during the previous calendar year. ICF/ID facilities’ rates are excluded from the calculations. (3-30-07)

ii. The rate will be calculated by the Department by March 15 of each calendar year. The rate will be based on the previous calendar year and effective retroactively for dates of service on or after January 1 of the respective year. (3-30-07)

iii. The weighted average rate for nursing facility swing-bed days will be calculated by dividing total payments for routine services, including patient contribution amounts but excluding miscellaneous financial transactions relating to prior years, by total patient days for each respective level of care occurring in the previous calendar year. (3-30-07)

iv. Routine services include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits,” Subsection 225.01. (3-30-07)

v. The Department will pay the lesser of the established rate, the facility’s charge, or the facility’s charge to private pay patients for “swing-bed” services. (3-30-07)

vi. Reimbursement of ancillary services not included in the nursing facility rates furnished for extended care services will be billed and determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (3-30-07)

vii. The number of swing-bed days that may be reimbursed to a provider in a twelve (12) month period will be limited to the greater of one thousand ninety five (1,095) days which may be prorated over a shorter fiscal period or, fifteen percent (15%) of the product of the average number of available licensed beds in the hospital in the period and the number of days in the fiscal period. (3-30-07)

d. Computation of “Swing-Bed” Patient Contribution. The computation of the patient’s contribution of swing-bed payment will be in accordance with IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits,” Section 224. (3-30-07)

09. Adjustment for Disproportionate Share Hospitals (DSH). All Idaho hospitals serving a disproportionate share of low income patients must qualify either as a Mandatory DSH or as Deemed DSH to receive a DSH payment. (3-29-10)

a. DSH Survey Requirements. The Department will send each hospital a DSH survey on or before January 31 of each calendar year. The DSH survey must be returned to the Department on or before May 31 of the same calendar year. A hospital will not receive a DSH payment if the survey is not returned by the deadline, unless good cause is determined by the Department. No later than July 15 of each calendar year, the Department must notify each hospital of their calculated DSH payment and notify each hospital of its preliminary calculated distribution amount. A hospital may file an amended survey to complete, correct, or revise the original DSH survey by submitting the amended survey and supporting documentation to the Department no later than thirty (30) days after the notice of the preliminary DSH calculation is mailed to the hospital. The state's annual DSH allotment payment will be made by September 30 of the same calendar year based on the final DSH surveys and Department data. (3-30-07)

b. Mandatory Eligibility. Mandatory Eligibility for DSH status will be provided for hospitals which: (3-30-07)

i. Meet or exceed the disproportionate share threshold as defined in Subsection 400.13 of these rules. (3-30-07)

ii. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services. (3-29-10)

(1) Subsection 405.09.b.ii. of this rule does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or (3-30-07)

(2) Does not offer nonemergency inpatient obstetric services as of December 21, 1987. (3-30-07)

iii. The MUR will not be less than one percent (1%). (3-30-07)

iv. If an Idaho hospital exceeds both disproportionate share thresholds, as described in Subsection 400.13 of these rules, and the criteria of Subsections 405.09.b.ii. and 405.09.b.iii. of this rule are met, the payment adjustment will be the greater of the amounts calculated using the methods identified in Subsections 405.09.b.vi. through 405.09.b.x. of this rule. (3-29-10)

v. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one (1) standard deviation and less than one and one-half (1 1/2) standard deviations above the mean of all Idaho hospitals will receive a DSH payment equal to two percent (2%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

vi. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one and one-half (1 1/2) standard deviations and less than two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

vii. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates exceeding two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to six

percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

viii. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding twenty-five percent (25%) will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

ix. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to, or exceeding, thirty percent (30%) will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

c. Deemed Disproportionate Share Hospital (DSH). All hospitals in Idaho which have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days, and meet the requirements unrelated to patient day utilization specified in Subsection 405.09.b. of this rule, will be designated a Deemed Disproportionate Share Hospital. The disproportionate share payment to a Deemed DSH hospital will be the greater of: (3-29-10)

i. Five dollars (\$5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or (3-30-07)

ii. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the DSH allotment amount, less the Mandatory DSH payment amount, divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals. (3-30-07)

d. Insufficient DSH Allotment Amounts. When the DSH allotment amount is insufficient to make the aggregate amount of DSH payments to each DSH hospital, payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. (3-30-07)

e. DSH Payments Will Not Exceed Costs. A DSH payment will not exceed the costs incurred during the year of furnishing services to individuals who are either eligible for medical assistance under the State Plan or were uninsured for health care services provided during the year. (3-30-07)

i. Payments made to a hospital for services provided to indigent patients by a state or a unit of local government within a state will not be considered a source of third party payment. (3-30-07)

ii. Claims of uninsured costs which increase the maximum amount which a hospital may receive as a DSH payment must be documented. (3-30-07)

f. DSH Will be Calculated on an Annual Basis. A change in a provider's allowable costs as a result of a reopening or appeal will not result in the recomputation of the provider's annual DSH payment. (3-30-07)

g. To the extent that audit findings demonstrate that DSH payments exceed the documented hospital specific cost limits, the Department will collect overpayments and redistribute DSH payments. (4-7-11)

i. If at any time during an audit the Department discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Department's final audit report regarding that provider, will be referred to the Medicaid Fraud Unit of the Idaho Attorney General's Office. (4-7-11)

ii. The Department will submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with 42 CFR Part 455, Subpart D, "Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments." (4-7-11)

iii. Beginning with FFY 2011, if based on the audit of the DSH allotment distribution, the Department determines that there was an overpayment to a provider, the Department will immediately: (4-7-11)

(1) Recover the overpayment from the provider; and (4-7-11)

(2) Redistribute the amount in overpayment to providers that had not exceeded the hospital-specific upper payment limit during the period in which the DSH payments were determined. The payments will be subject to

hospital-specific upper payment limits. (4-7-11)

iv. Disproportionate share payments must not exceed the DSH state allotment, except as otherwise required by the Social Security Act. In no event is the Department obligated to use State Medicaid funds to pay more than the State Medicaid percentage of DSH payments due a provider. (4-7-11)

10. Out-of-State Hospitals. (3-30-07)

a. Cost Settlements for Certain Out-of-State Hospitals. Hospitals not located in the state of Idaho will have a cost settlement computed with the state of Idaho if the following conditions are met: (3-30-07)

i. Total inpatient and outpatient covered charges are more than fifty thousand dollars (\$50,000) in the fiscal year; or (3-30-07)

ii. When less than fifty thousand dollars (\$50,000) of covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department. (3-30-07)

b. Payment for Hospitals Without Cost Settlement. Those out-of-state hospitals not cost settling with the state will have annually adjusted rates of payment no greater than seventy-five percent (75%) for inpatient covered charges and no greater than eighty percent (80%) of outpatient covered charges or, the Department's established fee schedule for certain outpatient services. These rates represent average inpatient and outpatient reimbursement rates paid to Idaho hospitals. (3-30-07)

~~**11. Institutions for Mental Disease (IMD).** Except for individuals under twenty two (22) years of age which are contracted with the Department under the authority of the Division of Family and Community Services and certified by the Health Care Financing Administration, no services related to inpatient care will be covered when admitted to a freestanding psychiatric hospital. (3-30-07)~~

121. Audit Function. Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Title XVIII and Medicaid purposes. The Department may elect to perform an audit even though the Medicare Intermediary does not choose to audit the facility. (3-30-07)

132. Adequacy of Cost Information. Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to participants. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another. (3-30-07)

143. Availability of Records of Hospital Providers. A participating hospital provider of services must make available to the Department in the state in which the facility is licensed, the provider's fiscal and other necessary records for the purpose of determining its ongoing record keeping capability and to ascertain information pertinent to the determination of the proper amount of program payments due the provider. (3-30-07)

154. Interim Cost Settlements. The Department may initiate or a hospital may request an interim cost settlement based on the Medicare cost report as submitted to the Medicare Intermediary. (3-30-07)

a. Cost Report Data. Interim settlement cost report data will be adjusted to reflect Medicaid payments and statistical summary reports sent to providers before the filing deadline. (3-30-07)

b. Hard Copy of Cost Report. Hospitals which request to undergo interim cost settlement with Idaho Medicaid must submit a hard copy of the Medicare cost report to the Department upon filing with the Intermediary. (3-30-07)

c. Limit or Recovery of Payment. The Department may limit a recovery or payment of an interim settlement amount up to twenty-five percent (25%) of the total settlement amount when the cost report information is in dispute. (3-30-07)

165. **Notice of Program Reimbursement.** Following receipt of the finalized Medicare cost report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider which sets forth the amounts of underpayment or overpayment made to the provider. The notice of the results of the final retroactive adjustment will be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Medicaid program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. Such action of recovery or suspension will continue even after a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments will be made to the settlement amount. (3-30-07)

a. Timing of Notice. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the cost report from the Medicare Intermediary. (3-30-07)

b. Reopening of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three (3) year period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the cost report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement. (3-30-07)

176. **Nonappealable Items.** The formula for the determination of the ~~H~~hospital ~~I~~inflation ~~I~~index, the principles of reimbursement which define allowable cost, non-Medicaid program issues, interim rates which are in compliance with state and federal rules, and the preliminary adjustments prior to final cost settlement determinations as supported by properly completed cost reports and audits must not be accepted as appealable items. ~~(3-30-07)~~()

187. **Interim Reimbursement Rates.** The interim reimbursement rates are reasonable and adequate to meet the necessary costs which must be incurred by economically and efficiently operated providers which provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. (3-30-07)

a. Annual Adjustments. Interim rates will be adjusted at least annually based on the best information available to the Department. The interim rate will reflect the Medicaid Inpatient Operating Cost Limits used to set inpatient rates and the Reimbursement Floor Percentage. (3-30-07)

b. Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (3-30-07)

c. Basis for Adjustments. The Department may make an adjustment based on the Medicare cost report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. If the settlement amount is equal to or greater than ten percent (10%) of the payments received or paid and equal to or greater than one hundred thousand dollars (\$100,000), the interim rate will be adjusted to account for half (½) of the difference. (3-30-07)

d. Unadjusted Rate. The Medicaid interim reimbursement rate on file is synonymous with the term unadjusted rate used by other payors. (3-30-07)

198. **Audits.** All financial reports are subject to audit by Departmental representatives in accordance with Section 305 of these rules. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

500. PHYSICIAN SERVICES: DEFINITIONS.

01. Physician Services. Physician services include the treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and to the restrictions and exclusions of coverage contained in Section 390 and ~~Subsection 502.01~~ of these rules. ~~Physician services as defined in Subsection 500.01 of this rule will be reimbursed by the Department.~~ (5-8-09)()

02. Telehealth. Telehealth as defined in Title 54, Chapter 57, Idaho Code. (3-25-16)

501. (RESERVED)

502. PHYSICIAN SERVICES: COVERAGE AND LIMITATIONS.

~~**01. Outpatient Psychiatric Mental Health Services.** Physician services not provided through the IBHP as outpatient psychiatric mental health services are limited to twelve (12) hours of psychiatric evaluations per eligible participant in any twelve (12) month period; and any combination of individual or group psychotherapy services provided by a physician up to a maximum of forty five (45) hours of service in the consecutive twelve (12) months period beginning with the first such service. (3-20-14)~~

021. Sterilization Procedures. ~~Particular~~ Restrictions pertaining to payment for sterilization procedures are contained in Sections 680 through 686 of these rules. (3-30-07)()

~~**032. Abortions.** Restrictions governing payment for abortions are contained in Sections 511 through 514 of these rules. (3-30-07)~~

043. Tonometry. Payment for tonometry is limited to one (1) examination for individuals over the age of forty (40) years during any twelve (12) month period (in addition to tonometry as a component of examination to determine visual acuity). In the event examination to determine visual acuity is not done, two (2) tonometry examinations per twelve (12) month period are allowed for participants over the age of forty (40). This limitation does not apply to participants receiving continuing treatment for glaucoma. (3-30-07)()

054. Physical Therapy Services. Payment for physical therapy services performed in the physician's office is limited to those services which are described and supported by the diagnosis. (3-30-07)

065. Injectable Vitamins. Payment for allowable injectable vitamins will be allowed when supported by the diagnosis. Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination. (3-30-07)

~~**076. Corneal Transplants and Kidney Transplants.** Corneal transplants and kidney transplants are covered by the Medical Assistance Program. (3-30-07)~~

~~**087. Telehealth.** Synchronous interaction telehealth encounters, delivered as defined in Title 54, Chapter 57, Idaho Code, are reimbursable as follows: (3-25-16)~~

~~**a.** Physician services delivered via telehealth are subject to primary care provider communication requirements in Section 210 of these rules. The Department will define limitations for telehealth in the Idaho Medicaid Provider Handbook to promote quality services and program integrity. (3-25-16)~~

~~**b.** Fee for service reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a physician and a participant. (3-25-16)~~

(BREAK IN CONTINUITY OF SECTIONS)

~~**700. (RESERVED)**~~

700. INPATIENT BEHAVIORAL HEALTH SERVICES: DEFINITIONS.

01. Freestanding Psychiatric Hospital. A hospital, nursing facility, or other institution of sixteen (16) beds or less that is primarily engaged in the diagnosis and treatment of mental diseases. The hospital is not considered freestanding if it shares a building or campus with another hospital, or is owned by another hospital. ()

02. Hospital Psychiatric Unit. The psychiatric unit of a general hospital that furnishes inpatient care and treatment services for mental illness under a psychiatrist or other physician qualified to treat mental diseases. ()

03. Institutions for Mental Disease (IMD). A hospital, nursing facility or other institution of seventeen (17) beds or more that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. A specific licensure is not necessary to meet this definition. This definition does not apply to ICF/IDs. ()

04. Substance Use Disorder. A substance use disorder is evidenced by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using a substance despite significant substance-related problems. A diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance and the current DSM. ()

701. INPATIENT ~~PSYCHIATRIC HOSPITAL~~ BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.

01. Inpatient Psychiatric Hospital Services. Participants ~~must~~ are eligible who have a DSM-5 diagnosis from the current DSM with substantial impairment in thought, mood, perception, or behavior. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for these services. Medical necessity must be demonstrated for admission or extended stay by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. Services may be provided in: (3-30-07)()

a. A freestanding psychiatric hospital; ()

b. A hospital psychiatric unit; ()

c. Institutions for mental disease for participants meeting the conditions in Subsections 701.01.c.i. and 701.01.c.ii. of this rule; ()

i. Participants must be under the age of twenty-one (21); and ()

ii. If a participant reaches age twenty-one (21) while receiving services, he may continue inpatient treatment until services are no longer required, or he reaches age twenty-two (22), whichever comes first. ()

02. Inpatient Substance Use Disorder Services. Participants are eligible when medical necessity is demonstrated by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for these services. Services may be provided in: ()

a. A freestanding psychiatric hospital; or ()

b. A hospital psychiatric unit. ()

03. ~~Medical Necessity Criteria~~ Severity of Illness Criteria. Both severity of illness and intensity of services criteria must be met for admission to an IMD or psychiatric unit of a general hospital. (3-30-07)()

a. Severity of illness criteria. The child participant must meet one (1) of the following criteria related to the severity of his psychiatric illness: (3-30-07)()

- i. Is currently dangerous to self as indicated by at least one (1) of the following: (3-30-07)
- (1) Has actually made an attempt to take his own life in the last seventy-two (72) hours (details of the attempt must be documented); or (3-30-07)
- (2) Has demonstrated self-mutilative behavior within the past seventy-two (72) hours (details of the behavior must be documented); or (3-30-07)
- (3) Has a clear plan to seriously harm himself, overt suicidal intent, and lethal means available to follow the plan (this information can be from the child participant or a reliable source and details of the child participant's plan must be documented); or (3-30-07)()
- (4) ~~A mental health professional has information from the child or a reliable source that the child~~ The participant has a current plan, specific intent, or recurrent thoughts to seriously harm himself or others, and is at significant risk to of making an attempt ~~to carry out the plan~~ without immediate intervention ~~(details must be documented);~~ or (3-30-07)()
- ii. Child Participant is actively violent or aggressive and exhibits homicidal ideation or other symptoms which indicate he is a probable danger to others as indicated by one (1) of the following: (3-30-07)()
- (1) The child participant has ~~actually~~ engaged in or threatened behavior harmful or potentially harmful to others or caused serious damage to property which would pose a serious threat of injury or harm to others within the last twenty-four (24) hours (description of the behavior and extent of injury or damage must be documented, as well as the time the behavior occurred relative to the present); or (3-30-07)()
- (2) The child participant has made threats to kill or seriously injure others or to cause serious damage to property which would pose a threat of injury or harm to others and has effective means to carry out the threats (details of threats must be documented); or (3-30-07)()
- (3) A mental health professional has information from the child participant or a reliable source that the child participant has a current plan, specific intent, or recurrent thoughts to seriously harm others or property and is at significant risk of making the attempt without immediate intervention (details must be documented); or (3-30-07)()
- iii. Child Participant is gravely impaired as indicated by at least one (1) of the following criteria: (3-30-07)()
- (1) The child participant has such limited functioning that his physical safety and well being are in jeopardy due to his inability for basic self-care, judgment and decision making (details of the functional limitations must be documented); or (3-30-07)()
- (2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the child participant unmanageable and unable to cooperate in non-hospital treatment (details of the child participant's behaviors must be documented); or (3-30-07)()
- (3) There is a need for treatment, evaluation, or complex diagnostic testing where the child participant's level of functioning or communication precludes assessment and/or treatment in a non-hospital based setting, and may require close supervision of medication or behavior or both. (3-30-07)()
- (4) The participant is undergoing severe or medically complicated withdrawal from alcohol, opioids, stimulants, or sedatives. ()
- b04. Intensity of Service Criteria.** The child participant must meet all of the following criteria related to the intensity of services needed ~~to for treatment his mental illness.~~ (3-30-07)()
- ~~i. It is documented by the Regional Mental Health Authority that less restrictive services in the~~

~~community do not exist or do not meet the treatment or diagnostic needs of the child, or the child has been unresponsive to treatment at a less intensive level of care. The services considered, tried, and/or needed must be documented; and (3-30-07)~~

~~a. Documentation that ambulatory care resources available in the community do not meet the treatment needs of the participant; and ()~~

~~b. Ambulatory care resources available in the community do not meet the treatment needs of the participant; and ()~~

~~ii.c. The services provided in the hospital can reasonably be expected to improve the child participant's condition or prevent further regression so that inpatient services will no longer be needed; and (3-30-07)()~~

~~iii.d. Treatment of the child participant's psychiatric condition requires services on an inpatient basis, including twenty-four (24) hour nursing observation, under the direction of a psychiatrist. The child requiring this treatment must not be eligible for independent passes or unit passes without observation or being accompanied by hospital personnel or a responsible other. (3-30-07)()~~

~~ee. Exceptions. The requirement to meet intensity of service criteria may be waived for first-time admissions if severity of illness is met and the physician is unable to make a diagnosis or treatment decision while the child participant is in his current living situation. The waiver of the intensity of services requirement can be for no longer than forty-eight (48) hours and is not waivable for repeat hospitalizations. (3-30-07)()~~

025. Exclusions. If a **child participant** meets one (1) or more of the following criteria, Medicaid reimbursement will be denied: (3-30-07)()

~~a. The child participant is unable to actively participate in an outpatient psychiatric treatment program solely because of a major medical condition, surgical illness or injury; or (3-30-07)()~~

~~b. The child demonstrates anti-social or criminal behavior or has criminal or legal charges against him and does not meet the severity of illness or intensity of service criteria; or (3-30-07)~~

~~c. The child has anti-social behaviors or conduct problems that are a danger to others but are not attributable to a mental illness (DSM-5) with substantial impairment in thought, mood or perception; or (3-30-07)~~

~~db. The child participant has a primary diagnosis of being intellectually disabled and the primary treatment need is related to the intellectual disability; or (3-30-07)()~~

~~e. The child lacks a place to live and/or family supports and does not meet severity of illness and intensity of service criteria; or (3-30-07)~~

~~f. The child has been suspended or expelled from school and does not meet severity of illness and intensity of service criteria. (3-30-07)~~

702. INPATIENT ~~PSYCHIATRIC HOSPITAL~~ **BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.**

~~01. **Emergency Admissions.** An emergency for purposes of a waiver of the prior authorization requirement is defined as the sudden onset of acute psychiatric symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part or death of the individual or harm to another person. A court-ordered admission or physician's emergency certificate does not, in itself, justify characterizing the admission as an emergency admission. The severity of illness and intensity of services criteria must be met. The hospital medical record of the admission must include documentation to support that the participant's status upon admission meets the definition of an emergency, as defined in Section 702 of this chapter of rules. The information for authorization of services must be FAXED, or otherwise delivered to the Department on the next business day following the emergency admission. Requests for authorization of emergency admissions must include the same information as required for elective admissions. (3-30-07)~~

01. Initial Length of Stay. ~~A prior authorization requirement for an initial length of stay will be established by the Department, or its designee, in the Idaho Medicaid Provider Handbook. Requirements for establishing length of stay will not be more restrictive than requirements for non-behavioral health services in a general hospital.~~ ()

02. Length of Extended Stay. ~~An initial length of stay will be established by the Department. An initial length of stay will usually be for no longer than five (5) days. For first time admissions where intensity of services criteria is not met the initial length of stay may not exceed forty-eight (48) hours. A hospital may request a continued stay review from the Department, or its designee, will establish authorization requirements in the Idaho Medicaid Provider Handbook. An authorization is necessary when the appropriate care of the participant indicates the need for hospital inpatient days in excess of the originally approved number. The continued stay review request may be made no later than the date authorized by the Department. Approval of additional days will be based on the following criteria: initial length of stay or previously approved extended stay.~~ (3-30-07)()

- ~~a. Documentation sufficient to demonstrate the medical necessity criteria is still met; (3-30-07)~~
- ~~b. A plan of care that includes documentation sufficient to demonstrate that the child's psychiatric condition continues to require services which can only be provided on an in-patient basis, including twenty-four (24) hour nursing observation, under the direction of a psychiatrist or other physician qualified to treat mental diseases; and (3-30-07)~~
- ~~c. Documentation sufficient to demonstrate the need for continued hospitalization, and that additional days at in-patient level of care will improve the participant's condition. (3-30-07)~~

03. Excluded Services Limited. ~~Inpatient psychiatric hospital services are limited to ten (10) days per year. Placement in an IMD for participants between the ages of twenty-one (21) and sixty-four (64) is not a covered service.~~ (3-30-07)()

703. INPATIENT ~~PSYCHIATRIC HOSPITAL~~ BEHAVIORAL HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

~~Admissions must be authorized by the Department.~~ (3-30-07)

01. Prior Authorization ~~for Elective Admissions.~~ ~~To qualify for reimbursement, prior authorization must be obtained from the Department prior to an elective admission. An elective admission is defined as one that is planned and scheduled in advance, and is not emergency in nature, as "emergency" is defined in Subsection 702.01 of these rules. Some services may require a prior authorization from the Department, or its designee. The Department will set documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services.~~ Requests for prior authorization must include: (3-30-07)()

- a. Diagnosis; and (3-30-07)
- b. Summary of present medical findings including symptoms, complaints and complications indicating the need for admission; and (3-30-07)
- c. Medical history; and (3-30-07)
- d. Mental and physical functional capacity; and (3-30-07)
- e. Prognosis; and (3-30-07)
- f. Recommendation by a physician for admission, preferably the primary care physician. If the ~~child~~ participant is enrolled in the Healthy Connections (HC) program, a HC referral is required. (3-30-07)()

02. Individual Plan of Care – Content. The individual plan of care is a written plan developed for the participant upon admission. ~~to an in-patient psychiatric hospital~~ The objective of the plan is to improve his condition to the extent that acute psychiatric care is no longer necessary. It must be developed by an interdisciplinary team as

defined in Subsection 703.03 of this rule. The plan of care must be ~~developed and~~ implemented within seventy-two (72) hours of admission, and reviewed at least every three (3) days., ~~and must~~ The individual plan of care must contain: (3-30-07)()

a. ~~Be based on a~~ A diagnostic evaluation that includes examination of the medical, behavioral, and developmental aspects of the participant's situation and reflects the ~~need~~ (medical necessity ~~criteria~~) for in-patient care; and (3-30-07)()

b. Treatment objectives related to conditions that necessitated the admission; and ()

c. An integrated program of therapies, treatments (including medications), activities (including special procedures to assure the health and safety of the participant), and experiences designed to meet the objectives; and ()

d. A discharge plan designed to achieve the participant's discharge at the earliest possible time that includes plans for coordination of community services to ensure continuity of care with the participant's family, school, and community upon discharge. ()

703. Individual Plan of Care – Interdisciplinary Team. ~~Be~~ The individual plan of care must be developed by an interdisciplinary team capable of assessing the ~~child participant's~~ immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities, assessing the potential resources of the ~~child participant's~~ family, setting the treatment objectives, and prescribing therapeutic modalities to achieve the plan's objectives. The team must include at a minimum: (3-30-07)()

a. One of the following: ()

- i. ~~A~~ B board-certified psychiatrist (~~preferably with a specialty in child psychiatry~~); or (3-30-07)()
- ii. A licensed psychologist and a physician licensed to practice medicine or osteopathy; or (3-30-07)
- iii. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental disease and a licensed clinical professional counselor; and (3-30-07)

b. One of the following: ()

i. ~~Either a~~ A licensed, clinical or master's social worker ~~or a registered nurse with specialized training or one (1) year's experience in treating mentally ill individuals (preferably children)~~; or (3-30-07)()

ii. A registered nurse with specialized training or one (1) year's experience in treating individuals with behavioral health needs; or ()

iii. A licensed occupational therapist who has had specialized training or one (1) year of experience in treating ~~mentally ill~~ individuals (~~preferably children~~); and with behavioral health needs. (3-30-07)()

iv. ~~The participant and his parents, legal guardians, or others into whose care he will be released after discharge.~~ (3-30-07)

c. ~~State treatment objectives (related to conditions that necessitated the admission); and~~ (3-30-07)

d. ~~Prescribe an integrated program of therapies, treatments (including medications), activities (including special procedures to assure the health and safety of the child), and experiences designed to meet the objectives;~~ and (3-30-07)

e. ~~Include a discharge and post discharge plan designed to achieve the child's discharge at the earliest possible time and include plans for coordination of community services to ensure continuity of care with the participant's family, school and community upon discharge.~~ (3-30-07)

704. INPATIENT ~~PSYCHIATRIC HOSPITAL~~ BEHAVIORAL HEALTH SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. **Provider Qualifications.** Inpatient hospital psychiatric services ~~for individuals under age twenty-one (21)~~ must be provided under the direction of a physician in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and licensed by the state of Idaho or the state in which they provide services. ~~Facilities currently providing psychiatric hospital services under the authority of Family and Community Services that are certified by the Health Care Financing Administration have until October 1, 1998 to comply with this requirement.~~ To provide services beyond emergency medical screening and stabilization treatment, the hospital must have a separate psychiatric unit with staff qualified to provide psychiatric services ~~to children~~. General hospitals licensed to provide services in Idaho ~~which~~ but are not JCAHO certified may not bill for psychiatric services beyond emergency screening and stabilization. (3-30-07)()

02. **Record Keeping.** A written report of each evaluation and the plan of care must be entered into the ~~child~~ participant's record at the time of admission or if the ~~child~~ participant is already in the facility, immediately upon completion of the evaluation or plan. (3-30-07)()

03. **Utilization Review (UR).** The facility must have in effect a written utilization review plan that provides for review of each ~~child~~ participant's need for the services that the hospital furnishes him. The UR plan must meet the requirements under 42 CFR 456.201 through 456.245. (3-30-07)()

705. INPATIENT ~~PSYCHIATRIC HOSPITAL~~ BEHAVIORAL HEALTH SERVICES: PROVIDER REIMBURSEMENT.

Failure to request a preadmission prior authorization, concurrent review, or continued stay review in a timely manner will result in a retrospective review being conducted by the Department. If the retrospective review determines the admission stay is medically necessary, the Department will assess a penalty to the hospital as specified in Subsection 705.02 of this rule. The ~~primary care~~ admitting physician will be assessed a penalty for failure to request a preadmission prior authorization, concurrent review, or continued stay review in a timely manner as specified in Subsection 705.03 of this rule. A physician who provides hospital care but has no control over the admission, continued stay, or discharge of the participant is not subject to this penalty. (3-30-07)()

01. **Payment.** Reimbursement for the participant's admission and length of stay is subject to preadmission prior authorization, concurrent review, continued stay review, or retrospective review by the Department. The hospital and the participant's physician are responsible for obtaining the required review. If such review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. (3-30-07)()

a. In reimbursing for inpatient hospital psychiatric services the Department will pay the lesser of customary charges or the reasonable cost of semi-private rates for inpatient hospital care in accordance with the rules set forth in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-30-07)

b. The cost of services that would be the responsibility of the Department of Education for school age children cannot be considered in the cost of inpatient psychiatric hospital services. (3-30-07)

~~c. The participant may be charged for services only when he or she has made an informed decision to incur expenses for services deemed not medically necessary by the Department. (3-30-07)~~

02. **Hospital Penalty Schedule.** Failure to request a preadmission prior authorization, concurrent review, or continued stay review from the Department in a timely manner will result in the hospital being assessed a penalty as follows. The penalty will be assessed after payment for hospital services for a medically necessary hospital admission. (3-30-07)()

a. A request for a preadmission or continued stay review that is one (1) day late will result in a penalty of two hundred sixty dollars (\$260). (3-30-07)

b. A request for a preadmission or continued stay review that is two (2) days late will result in a penalty of five hundred twenty dollars (\$520). (3-30-07)

c. A request for a preadmission or continued stay review that is three (3) days late will result in a penalty of seven hundred eighty dollars (\$780). (3-30-07)

d. A request for a preadmission or continued stay review that is four days (4) late will result in a penalty of one thousand forty dollars (\$1,040). (3-30-07)

e. A request for a preadmission or continued stay review that is five (5) or more days late will result in a penalty of one thousand three hundred dollars (\$1,300). (3-30-07)

03. Physician Penalty Schedule. Failure to request a preadmission review from the Department in a timely manner will result in the ~~primary care~~ admitting physician being assessed a penalty as follows. The penalty will not be assessed against a physician who provides hospital care but has no control over the admission, continued stay, or discharge of the participant. The penalty will be assessed after payment for physician services for a medically necessary hospital admission: ~~(3-30-07)~~()

a. A request for a preadmission review that is one (1) day late will result in a penalty of fifty dollars (\$50). (3-30-07)

b. A request for a preadmission review that is two (2) days late will result in a penalty of one hundred dollars (\$100). (3-30-07)

c. A request for a preadmission review that is three (3) days late will result in a penalty of one hundred fifty dollars (\$150). (3-30-07)

d. A request for a preadmission review that is four (4) days late will result in a penalty of two hundred dollars (\$200). (3-30-07)

e. A request for a preadmission review that is five (5) or more days late will result in a penalty of two hundred fifty dollars (\$250). (3-30-07)

706. INPATIENT ~~PSYCHIATRIC HOSPITAL~~ BEHAVIORAL HEALTH SERVICES: QUALITY ASSURANCE.

The policy, rules, and regulations to be followed must be those cited in 42 CFR 456.480 through 42 CFR 456.482. ~~(3-30-07)~~()

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1703

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

PUBLIC HEARING

Tuesday, October 17, 2017 — 2:00 p.m. (Local)

Central Idaho - DHW Office
3232 Elder Street
Conference Room D - East
Boise, ID 83705

TELECONFERENCE CALL-IN

Toll Free: 1-877-820-7831
Participant Code: 626553

The hearing site 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 a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The Department's Infant Toddler and Medicaid programs are both required by federal law to provide access and reimbursement for early intervention services. This rule change streamlines the processes between two Department Divisions and resolves the current access issue. Currently, the Infant Toddler Program has a waiting list of children, including Medicaid-eligible children, that are unable to access Part C, early intervention treatment services. The changes in this docket will keep the State in compliance in both areas, provide a more streamlined approach between the two Divisions, and will ensure improved access to these services for participants.

Specifically, early intervention service requirements are being removed from IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" and added as a new Section in this chapter. The rule text is being updated to support program eligibility, service coverage, limitations, provider, and reimbursement requirements. These changes will allow the Department more flexibility for collaboration within IDHW Divisions and ensure all Medicaid-eligible infants and toddlers receive the right preventive services, at the right time, through the best financial means for the State. Updates to references or other minor technical corrections are being made as needed.

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 as a result of this rulemaking:

This proposed change impacts the Division of Medicaid and the Division of Family and Community Services. Currently both divisions support these services for children with special healthcare needs from birth through the end of their 36th month of age through a combination of a federal grant and Medicaid benefits payments.

This rule will enable additional Medicaid coverage for these services, which will allow leveraging federal funds to support better services for Idaho. There is no overall impact to the general fund; however, a transfer of general funds between divisions will be necessary. In addition, the FACS division will require an increase of \$1,129,800 in federal spending authority and will revert \$1,126,700 in receipt spending authority.

The net impact will increase federal expenditures for these services but will not increase the general fund needs. This will allow us to increase services to children and use state general funds more efficiently.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 7, 2017, Idaho Administrative Bulletin, [Vol. 17-6, page 38](#).

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

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

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2017.

DATED this 1st day of September, 2017.

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 PROPOSED TEXT OF DOCKET NO. 16-0309-1703
(Only Those Sections With Amendments Are Shown.)

011. DEFINITIONS: I THROUGH O.

For the purposes of these rules, the following terms are used as defined below: (3-30-07)

01. ICF/ID. Intermediate Care Facility for People with Intellectual Disabilities. An ICF/ID is an entity licensed as an ICF/ID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (3-30-07)

02. Idaho Behavioral Health Plan (IBHP). The Idaho Behavioral Health Plan is a prepaid ambulatory health plan (PAHP) that provides outpatient behavioral health coverage for Medicaid-eligible children and adults. Outpatient behavioral health services include mental health and substance use disorder treatment as well as case management services. The coordination and provision of behavioral health services as authorized through the IBHP contract are provided to qualified, enrolled participants by a statewide network of professionally licensed and certified behavioral health providers. (3-20-14)

03. Idaho Infant Toddler Program. The Idaho Infant Toddler Program serves children from birth ~~up to three (3) years of age~~ ~~(through the end of their 36th month~~s~~), and must of age, who~~ meet the requirements and

provisions of the Individuals with Disabilities Education Act (IDEA), Part C; ~~the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C.~~ (7-1-13)()

- ~~a. These requirements for the Idaho Infant Toddler Program include: (7-1-13)~~
- ~~i. Adherence to procedural safeguards and time lines; (7-1-13)~~
- ~~ii. Use of multi-disciplinary assessments and Individualized Family Service Plans (IFSPs); (7-1-13)~~
- ~~iii. Provision of early intervention services in the natural environment; (7-1-13)~~
- ~~iv. Transition planning; and (7-1-13)~~
- ~~v. Program enrollment and reporting requirements. (7-1-13)~~
- ~~b. The Idaho Infant Toddler Program may provide the following services for Medicaid reimbursement: (7-1-13)~~
- ~~i. Occupational therapy; (7-1-13)~~
- ~~ii. Physical therapy; (7-1-13)~~
- ~~iii. Speech language pathology; (7-1-13)~~
- ~~iv. Audiology; and (7-1-13)~~
- ~~v. Children's developmental disabilities services defined under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-13)~~

04. In-Patient Hospital Services. Services that are ordinarily furnished in a hospital for the care and treatment of an in-patient under the direction of a physician or dentist except for those services provided in mental hospitals. (3-30-07)

05. Intermediary. Any organization that administers Title XIX or Title XXI; in this case the Department of Health and Welfare. (3-30-07)

06. Intermediate Care Facility Services. Those services furnished in an intermediate care facility as defined in 42 CFR 440.150, but excluding services provided in a Christian Science Sanatorium. (3-30-07)

07. Legal Representative. A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. (3-30-07)

08. Legend Drug. A drug that requires, by federal regulation or state rule, the order of a licensed medical practitioner before dispensing or administration to the patient. (3-30-07)

09. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (3-30-07)

10. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (3-30-07)

11. Lock-In Program. An administrative sanction, required of a participant found to have misused the services provided by the Medical Assistance Program. The participant is required to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. (3-30-07)

- 12. Locum Tenens/Reciprocal Billing.** The practice of a physician to retain a substitute physician when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician is called the “Locum Tenens” physician. Reimbursement to a Locum Tenens physician will be limited to a period of ninety (90) continuous days. Reciprocal billing occurs when a substitute physician covers the regular physician during an absence or on an on-call basis a period of fourteen (14) continuous days or less. (3-30-07)
- 13. Medical Assistance.** Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-30-07)
- 14. Medicaid.** Idaho's Medical Assistance Program. (3-30-07)
- 15. Medicaid-Related Ancillary Costs.** For the purpose of these rules, those services considered to be ancillary by Medicare cost reporting principles. Medicaid-related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid participants by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid-related ancillaries. (3-30-07)
- 16. Medical Necessity (Medically Necessary).** A service is medically necessary if: (3-30-07)
- a.** It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (3-30-07)
 - b.** There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly. (3-30-07)
 - c.** Medical services must be of a quality that meets professionally-recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (3-30-07)
- 17. Medical Supplies.** Healthcare-related items that are consumable, disposable, or cannot withstand repeated use by more than one (1) individual, are suitable for use in any setting in which normal life activities take place, and are reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. (7-1-17)
- 18. Medicare Durable Medical Equipment Medicare Administrative Contractor Jurisdiction D Supplier Manual (CMS/Medicare DME Coverage Manual).** A publication that is incorporated by reference in Section 004 of these rules and contains information on DME supplier enrollment, documentation, claim submission, coverage, appeals, and overpayments. (7-1-17)
- 19. Midwife.** An individual qualified as one of the following: (3-29-12)
- a.** Licensed Midwife. A person who is licensed by the Idaho Board of Midwifery under Title 54, Chapter 55, Idaho Code, and IDAPA 24.26.01, “Rules of the Idaho Board of Midwifery.” (3-29-12)
 - b.** Nurse Midwife (NM). An advanced practice registered nurse who is licensed by the Idaho Board of Nursing and who meets all the applicable requirements to practice as a nurse midwife under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, “Rules of the Idaho Board of Nursing.” (3-29-12)
- 20. Nominal Charges.** A public provider’s charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the services provided. (3-30-07)
- 21. Nonambulatory.** Unable to walk without assistance. (3-30-07)
- 22. Non-Legend Drug.** Any drug the distribution of which is not subject to the ordering, dispensing, or administering by a licensed medical practitioner. (3-30-07)

23. Non-Physician Practitioner. A non-physician practitioner, previously referred to as a midlevel practitioner, comprises the following practitioner types: certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives (NM), clinical nurse specialists (CNS), and physician assistants (PA), as defined in Sections 010, 011, 012 of these rules. (7-1-17)

24. Nurse Practitioner (NP). A registered nurse or licensed professional nurse (RN) who meets all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (7-1-13)

25. Nursing Facility (NF). An institution, or distinct part of an institution, that is primarily engaged in providing skilled nursing care and related services for participants. It is an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. Participants must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. (3-30-07)

26. Orthotic. Pertaining to or promoting the support of an impaired joint or limb. (3-30-07)

27. Outpatient Hospital Services. Preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to a patient not in need of inpatient hospital care. (3-30-07)

28. Out-of-State Care. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (3-30-07)

29. Oxygen-Related Equipment. Equipment which is utilized or acquired for the routine administration of oxygen in any setting in which normal life activities take place. This includes oxygen tanks, regulators, humidification nebulizers, oxygen concentrators, and related equipment. Equipment which is used solely for the administration of medication into the lungs is excluded from this definition. (7-1-17)

(BREAK IN CONTINUITY OF SECTIONS)

585. EARLY INTERVENTION SERVICES.

Early Intervention Services for infants and toddlers enrolled in Idaho Medicaid are provided by the Idaho Infant Toddler Program (ITP). Early Intervention Services must be provided in accordance with the Individuals with Disabilities Education Act (IDEA), Part C, and all Medicaid regulations. ()

586. EARLY INTERVENTION SERVICES: PROGRAM REQUIREMENTS.

Idaho Medicaid and the ITP coordinate the delivery of Early Intervention Services through an intra-agency agreement published on the Department's website. Program requirements include: ()

01. Physician Recommendation. The ITP can bill for health-related services provided to eligible children when the services are documented as medically necessary and provided under the recommendation of a physician. ITP may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated physician recommendation. The recommendation is valid for up to three hundred sixty-five (365) days. ()

02. Individualized Family Service Plan (IFSP). The ITP may bill for Medicaid services covered by a current IFSP. The plan must be developed by a multi-disciplinary team and be based on the results of assessment(s). ()

03. Qualified Staff. ITP staff qualifications must meet IDEA Part C requirements, and all Medicaid regulations as specified in the intra-agency agreement. ()

587. EARLY INTERVENTION SERVICES: PROVIDER REIMBURSEMENT.

Medicaid will reimburse the Infant Toddler Program for covered medically necessary services. ()

01. Fee Schedule. Reimbursement for Early Intervention Services will be based on the Idaho Medicaid Fee Schedule for Early Intervention. ()

02. Payment Review. Reimbursement is subject to pre-payment and post-payment review in accordance with Section 56-209(h)(j)(3), Idaho Code, and recoupment in accordance with IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." ()

5858. -- 589. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

732. THERAPY SERVICES: COVERAGE AND LIMITATIONS.

Therapy services are covered under these rules when delivered by a therapy professional and provided by one (1) of the following providers: outpatient hospitals, outpatient rehabilitation facilities, comprehensive outpatient rehabilitative facilities, nursing facilities, school-based services, ~~Idaho Infant Toddler Program~~, independent practitioners, and home health agencies. Therapy services provided by a home health agency under a home health plan of care must meet the requirements found in Sections 730 through 739 of these rules, and the requirements found in Sections 720 through 729 of these rules. (7-1-17)()

01. Service Description: Occupational Therapy and Physical Therapy. Modalities, therapeutic procedures, tests, and measurements as described in the Physical Medicine and Rehabilitation Subsection and the Neurology and Neuromuscular Procedures Subsection of the Physician's Current Procedural Terminology (CPT Manual) are covered with the following limitations: (4-2-08)

a. Any evaluation or re-evaluation may only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. (4-2-08)

b. Any CPT procedure code that falls under the heading of either, "Active Wound Care Management," or "Tests and Measurements," requires the therapist to have direct, one-to-one, patient contact. (4-2-08)

c. The therapist may be reimbursed for the technical component of muscle testing, joint range of motion, electromyography, or nerve velocity determinations as described in the CPT Manual when ordered by a physician, nurse practitioner, or physician assistant. (4-2-08)

d. Any assessment provided under the heading "Orthotic Management and Prosthetic Management" must be completed by the therapist. (4-2-08)

e. Any modality that is defined as "unlisted" in the CPT Manual requires prior authorization by the Department. In this case, the therapist and the physician, nurse practitioner, or physician assistant must provide information in writing to the Department that documents the medical necessity of the modality requested. (4-2-08)

f. The services of occupational or physical therapy assistants used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising therapist. Therapy assistants may not provide evaluation services, make clinical judgments or decisions, or take responsibility for the service. The therapist has full responsibility for the service provided. Therapy assistants act at the direction and under the supervision of the treating therapist and in accordance with state licensure rules. (7-1-16)

02. Service Description: Speech-Language Pathology. Speech-language pathology services must be provided as defined in Section 730 of these rules. Services provided by speech-language pathology aides and assistants are considered unskilled services, and will be denied as not medically necessary if they are billed as speech-language pathology services. (7-1-16)

03. Non-Covered Services: Occupational Therapy, Physical Therapy, and Speech-Language Pathology. (4-2-08)

- a.** Continuing services for participants who do not exhibit the capability to achieve measurable improvement and who do not meet the criteria for a maintenance program. (7-1-16)
- b.** Services that address developmentally acceptable error patterns. (4-2-08)
- c.** Services that do not require the skills of a therapy professional. (7-1-16)
- d.** Massage, work hardening, and conditioning. (4-2-08)
- e.** Services that are not medically necessary, as defined in Section 011 of these rules. (4-2-08)
- f.** Duplicate services, as defined under Section 730 of these rules. (4-2-08)
- g.** Group therapy in settings other than school-based services and the Idaho Infant Toddler Program. (7-1-13)
- h.** Acupuncture (with or without electrical stimulation). (7-1-16)
- i.** Biofeedback, unless provided to treat urinary incontinence. (7-1-16)
- j.** Duplicate Services. (7-1-16)
- k.** Services that are considered to be experimental or investigational. (7-1-16)
- l.** Vocational Program. (7-1-16)
- m.** Vision Therapy. (7-1-16)
- 04. Service Limitations.** (4-2-08)

 - a.** Physical therapy (PT) and speech-language pathology (SLP) services are limited to a combined annual dollar amount for all PT and SLP services. The Department will set the total amount based on the annual Medicare caps. The Department may authorize additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided upon request of the Department. (7-1-17)
 - b.** Occupational therapy services are limited to an annual dollar amount set by the Department based on the annual Medicare caps. The Department may authorize additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided upon request of the Department. (7-1-17)
 - c.** Exceptions to service limitations. (3-29-12)

 - i.** Therapy provided by home health agencies is subject to the limitations on home health services contained in Section 722 of these rules. (3-29-12)
 - ii.** Therapy provided through school-based services or the Idaho Infant Toddler Program is not included in the service limitations under Subsection 732.04 of this rule. (7-1-13)
 - iii.** Therapy provided to EPSDT participants under the age of twenty-one (21) in accordance with the EPSDT requirements contained in Sections 881 through 883 of these rules, and in Section 1905(r) of the Social Security Act, will be authorized by the Department when additional therapy services are medically necessary. (3-29-12)
 - d.** Feeding therapy services are covered for children with a diagnosed feeding disorder that results in a clinically significant deviation from normal childhood development. The provider of feeding therapy is an occupational therapist or speech therapist with training specific to feeding therapy. (7-1-16)

e. Maintenance therapy is covered when an individualized assessment of the participant's condition demonstrates that skilled care is required to carry out a safe and effective maintenance program. (7-1-16)

f. Telehealth modalities are covered to the extent they are allowed under the rules of the applicable board of licensing. The Department will define limitations on telehealth in the provider handbook to promote quality services and program integrity. (7-1-16)

(BREAK IN CONTINUITY OF SECTIONS)

735. THERAPY SERVICES: PROVIDER REIMBURSEMENT.

01. Payment for Therapy Services. The payment for therapy includes the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the participant for the use of such equipment. (4-2-08)

02. Payment Procedures. Payment procedures are as follows: (3-30-07)

a. Therapy provided by home health agencies will be paid at a per visit rate as described in Section 725 of these rules and in accordance with IDAPA 16.03.07, "Rules for Home Health Agencies." (4-2-08)

b. Therapists enrolled with Medicaid as independent practitioners and licensed by the appropriate state licensing board will be reimbursed on a fee-for-service basis. Only those independent practitioners who have been enrolled as Medicaid providers can bill the Department directly for their services. A therapy assistant cannot bill Medicaid directly. The maximum fee will be based upon the Department's fee schedule, available from the central office for the Division of Medicaid, the contact information for which is found in Section 005 of these rules. (3-20-14)

c. Therapy rendered on-site to hospital inpatients or outpatients will be paid at a rate not to exceed the payment determined as reasonable cost using Title XVIII (Medicare) standards and principles. (4-2-08)

d. Payment for therapy services rendered to participants in long-term care facilities is included in the facility reimbursement as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-13)

e. Payment for therapy services rendered to participants in school-based services is described in Section 855 of these rules. (4-2-08)

~~f. Payment for therapy services rendered by the Idaho Infant Toddler Program will be reimbursed on a fee for service basis. (7-1-13)~~

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1704

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

PUBLIC HEARING

Monday, October 23, 2017 — 3:00 p.m. (MDT)

**Medicaid Central Office
3232 Elder Street
Conference Room D - West/East
Boise, ID 83705**

TELECONFERENCE CALL-IN

**Toll Free: 1-877-820-7831
Participant Code: 301388**

The hearing site 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 a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under a court-approved settlement agreement, the Department is implementing the use of a new assessment tool to replace the SIB-R assessment tool. The Department uses assessment tools to determine developmental disability eligibility, waiver eligibility, skill level, and the participant's budget for services. Reference to the SIB-R assessment tool is being removed from this chapter.

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 as a result of this rulemaking:

The fiscal impact to implement and use a new assessment tool is a total of \$909,375. These costs are funded by 71.26% (\$648,020) federal funds and 28.74% (\$261,355) state general funds. The costs to the state were included in the SFY 2018 budget previously approved by the 2017 Legislature.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Department determined it was not feasible to do negotiated rulemaking because the change is being made to comply with a court-approved settlement agreement.

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: The SIB-R Comprehensive Manual is being deleted from the documents that are incorporated by reference in this chapter of rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Karen Westbrook at (208) 364-1960.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2017.

DATED this 1st day of September, 2017.

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
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THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0309-1704
(Only Those Sections With Amendments Are Shown.)

004. INCORPORATION BY REFERENCE.

The following are incorporated by reference in this chapter of rules: (3-30-07)

01. American Speech-Language-Hearing Association (ASHA): Medicaid Guidance for Speech-Language Pathology Services. The American Speech-Language-Hearing Association (2004) Medicaid Guidance for Speech-Language Pathology Services: Addressing the “Under the Direction of” Rule technical report is available on the internet at: <http://www.asha.org/policy/ps2004-00098.htm>. The report may also be obtained at the ASHA National Office, 2200 Research Boulevard, Rockville, MD 20850-3289, telephone (301) 296-5700. (3-29-10)

02. DSM-5. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) Arlington, VA, American Psychiatric Association, 2013. A copy of the manual is available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. (3-20-14)

03. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 East Chicago Avenue, Chicago, IL, 60611. (3-30-07)

04. Medicare Durable Medical Equipment Medicare Administrative Contractor Jurisdiction D Supplier Manual 2016, As Amended (CMS/Medicare DME Coverage Manual). Since the supplier manual is amended on a quarterly basis by CMS, the current year's manual is being incorporated by reference, as amended, to allow for the incorporation of the most recent amendments to the manual. The full text of the CMS/Medicare DME Coverage Manual is available via the Internet at <https://med.noridianmedicare.com/web/jddme/education/supplier-manual>. (7-1-17)

05. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II (CMS Publication 15-1 and 15-2), is available on the CMS website at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html>. (3-30-07)

~~**06. SIB-R Comprehensive Manual. Scales of Independent Behavior—Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL 60143-2079. A copy is available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho 83702.**~~ (3-30-07)

07.6. Travel Policies and Procedures of the Idaho State Board of Examiners. The text of “Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners,” Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at <http://www.sco.idaho.gov>. (3-30-07)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.18 – MEDICAID COST-SHARING

DOCKET NO. 16-0318-1701 (FEE RULE)

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b), 56-253, and 56-257, Idaho Code; and House Bill 43 (2017).

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

PUBLIC HEARING
Wednesday, October 18, 2017 — 9:00 a.m. (Local)

Central Idaho - DHW Office
3232 Elder Street
Conference Room D - East
Boise, ID 83705

The hearing site 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 a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These rule changes will enable the Department to charge a monthly premium to YES participants whose family income is above Title XIX income limits. The Department is charging a premium to comply with the cost-sharing provisions in Section 56-257, Idaho Code, as well as to uphold parity among similar programs targeting populations of Idaho children with special health care needs.

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

The Department will establish a premium fee schedule at rates not to exceed maximums set forth in federal law (i.e., the aggregate limit of five percent (5%) of the family's income at 42 CFR 447.56) and regulations governing state Medicaid programs. The fee schedule will be published on the Department's website and provided to families participating in the Youth Empowerment Services (YES) program who are subject to premiums. This monthly premium may be waived if the Department determines that the family is unable to participate in the cost of care. The fee is being imposed pursuant to Section 56-257, Idaho Code.

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 as a result of this rulemaking:

The costs for the Youth Empowerment Services (YES) program were originally estimated in the fiscal note for House Bill 43 (2017) and funding addressed in House Bill 313 the same year, which provided legislative direction to pursue premiums for families of children with serious emotional disturbance. This cost-sharing rule establishes a sliding scale premium for eligible YES participants over 150% of the Federal Poverty Guidelines. Based on similar premium cost sharing methodologies, it is estimated that these premiums will generate approximately \$57,000 in receipts in SFY 2019, \$86,000 in SFY 2020, and \$115,000 in SFY 2021. These premiums will contribute to offsetting future costs of the YES program as services are implemented over time.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 7, 2017, Idaho Administrative Bulletin, [Vol. 17-6, pages 43 and 44](#).

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Clay Lord at (208) 364-1979.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2017.

DATED this 1st day of September, 2017.

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 PROPOSED TEXT OF FEE DOCKET NO. 16-0318-1701
(Only Those Sections With Amendments Are Shown.)

001. TITLE, SCOPE, AND POLICY.

01. Title. The title of this chapter is IDAPA 16.03.18, "Medicaid Cost-Sharing." (3-19-07)

02. Scope. ~~(3-21-12)~~

~~**a-** These rules describe the general requirements regarding the administration of the cost-sharing provisions for participation in a medical assistance program providing direct benefits in Idaho. (3-21-12)~~

~~**b-** *This chapter does not apply to participants receiving benefits under IDAPA 16.03.16, "Premium Assistance."* ~~(3-21-12)~~~~

03. Policy. It is the policy of the Department that certain participants share in the cost of their benefits. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

~~206. ~~209.~~ (RESERVED)~~

207. PREMIUMS FOR PARTICIPATION UNDER THE YOUTH EMPOWERMENT SERVICES (YES) PROGRAM.

01. Premium Fee Schedule. Each YES program participant, as that individual is defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 636, is subject to assessment of a premium based on family income. The Department will establish a premium fee schedule at rates not to exceed maximums set forth in federal law and regulations governing state Medicaid programs. The fee schedule will be published on the Department's website and provided to families participating in the YES program who are subject to premiums. ()

02. Enforcement of Premiums. Payment of premiums will be enforced within the limitations of federal laws and regulations governing state Medicaid programs. ()

03. Waiver of Premium. The monthly premium described in Subsection 207.01 of this rule may be waived if the Department determines that the family is unable to participate in the cost of care. ()

04. Premium Recalculation. The premium amount is recalculated at each annual eligibility redetermination. If a financially responsible adult reports a reduction in family income prior to eligibility redetermination, the premium will be reduced to the appropriate level upon verification of the reduction in the family's income. When the family income is reduced to a level that does not require premium payments, the premium will no longer be assessed. ()

208. -- 209. (RESERVED)

COST/BENEFIT ANALYSIS FORM

Department of Health and Welfare
Administrative Rules Unit (ARU)

Docket Number: 16-0318-1701

Agency Contact: Clay Lord
Phone: 364-1979

Rules Specialist: Frank Powell
Phone: 334-5775

Date Analysis Completed: 6/22/17 (revised 9/01/17)

IDAPA Chapter Number and Title: IDAPA 16.03.18, "Medicaid Cost-Sharing"

Fee Rule Status: Proposed Temporary **Effective date:** July 1, 2018

Instructions:

Section 67-5223(3), Idaho Code, adopted by the 2010 Legislature, requires that all proposed rules in which a fee or charge is imposed or increased must include a cost/benefit analysis of the rule change at the time the rule text is submitted for publication. This analysis needs to include an estimated cost to the agency to implement the rule and an estimated cost to be borne by citizens, or the private sector, or both. This statute change is effective July 1, 2010, and must be completed for fee rules published in the *Idaho Administrative Bulletin* after that date.

Cost/Benefit Analysis For This Rule Change:

The costs for the Youth Empowerment Services (YES) program were originally estimated by DFM as a fiscal note for House Bill 43 (2017) and funding addressed in House Bill 313 the same year, which provided legislative direction to pursue premiums for families of children with serious emotional disturbance. This cost-sharing rule establishes a sliding scale premium for eligible YES participants over 150% of the Federal Poverty Guidelines. Based on similar premium cost sharing methodologies, it is estimated that these premiums will generate approximately \$57,000 in receipts in SFY 2019, \$86,000 in SFY 2020, and \$115,000 in SFY 2021.

These premiums will contribute to offsetting future costs of the YES program as services are implemented over time; however, outside of the cost offsets enumerated above, cost-sharing receipts will not impact costs to be borne by citizens or the private sector.