IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1105

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 1, 2011.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code, and House Bill 260 (2011) codified in Sections 56-255, 56-257, and 56-260 through 56-266, Idaho Code, as amended.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

Wednesday, October 12, 2011 2:00 p.m. MDT	Thursday, October 13, 2011 2:00 p.m. PDT	Friday, October 14, 2011 2:00 p.m. MDT
State Office Building 2nd Floor Conf. Rm. 150 Shoup Avenue Idaho Falls, ID	Health & Welfare Region I Lower Level Conf. Room 1120 Ironwood Drive, Suite 102 Coeur d'Alene, ID	Medicaid Central Office Conf. Rooms D East & West 3232 Elder Street Boise, ID

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

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

Rule changes are being made to align these rules with House Bill 260 passed by the 2011 Legislature. Under Section 56-255, Idaho Code, as amended by House Bill 260 (2011), the Department is adding a rule that requires mental health agency providers to meet national accreditation standards.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate to comply with deadlines in amendments to governing law or federal programs, in particular, House Bill 260 (2011).

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: None.

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done to bring this chapter of rules into compliance with House Bill 260 (2011).

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Carolyn Burt at (208) 364-1844.

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 26, 2011.

DATED this 23rd day of August, 2011.

Tamara Prisock
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THE FOLLOWING IS THE TEMPORARY RULE & PROPOSED TEXT OF DOCKET NO. 16-0309-1105

712. MENTAL HEALTH CLINIC SERVICES: CREDENTIALING RESPONSIBILITIES OF THE DEPARTMENT.

01. Reimbursement. In compliance with Section 56-255(3)(d), Idaho Code, mental health services must be delivered by providers that meet national accreditation standards. A mental health clinic must be designated as credentialed or provisionally credentialed in order to receive Medicaid reimbursement for services. Any agency that fails to achieve or maintain credentialed status will have its Medicaid provider agreement terminated.
~~*(5-8-09)*~~(10-1-11)T

02. Application. All existing providers and new provider applicants must submit an application for credentialing that will be reviewed in order to proceed with the credentialing process and obtain the required credential by the Department. All initial applications will be responded to within thirty (30) calendar days. If the application is incomplete or is not in substantial compliance with these rules, the applicant must submit the additional information within ten (10) business days of receipt of notice for the application to be considered further. The application will be reviewed up to three (3) times. If the applicant has not provided the required information by the third submittal, then the application will be denied and the application will not be considered again for twelve (12) months. (5-8-09)

03. Temporary Credentialed Status. In order for existing providers to be able to continue to provide services during initial development, the Department will grant a one-time temporary credential to all existing providers. (5-8-09)

04. New Providers. New provider applicants will be required to submit a credentialing application and successfully complete the credentialing application process as a condition for Department approval as a Medicaid provider. If the new provider applicant successfully passes the application portion of credentialing, then a temporary credential will be issued to the provider for up to one hundred eighty (180) days. Within the one hundred eighty (180) days, an on-site review will be conducted. If the provider applicant is deemed to be in substantial compliance with these rules, then the temporary credential will be converted to a full credential. If the provider fails to be in substantial compliance, then the temporary credential will expire, credentialed status will be denied, and the provider applicant will not be considered for credentialing again for twelve (12) months. (5-8-09)

05. Elements of Credentialing. The initial credentialing process consists of the application, self-study, and an on-site review for compliance with the requirements of these rules. (5-8-09)

a. The application provides documentation the agency has met the criteria set forth in these rules. Elements contained in the application include: (5-8-09)

i. Ownership and governance; (5-8-09)

ii. Physician contract for medical and clinical oversight and supervision; (5-8-09)

iii. Proof of appropriate insurance; (5-8-09)

iv. Appropriate employment and contract documentation; and (5-8-09)

v. Copies of relevant licenses and transcripts. (5-8-09)

b. The self-study provides the agency the opportunity to formally document policies and procedures that demonstrate compliance with Sections 713 and 714 of these rules. (5-8-09)

c. The on-site review provides the Department the opportunity to observe service delivery and ensure the agency actually implements and complies with their policies and procedures. (5-8-09)

06. Deemed Status. Providers accredited by private accreditation agencies, (i.e., the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or Commission on the Accreditation of Rehabilitation Facilities (CARF)), will be exempt from credentialing processes. Other accrediting agencies may be determined acceptable upon review by the Department. Providers must submit to the Department appropriate documentation of their private accreditation status. (5-8-09)

07. Expiration and Renewal of Credentialed Status. Credentials issued under these rules will be issued for a period up to three (3) years. Unless denied or revoked, the agency's credential will expire on the date designated by the Department. No later than ninety (90) days before expiration, an agency must apply for renewal of credentials. A site review may be conducted by the Department for renewal applications. (5-8-09)

08. Provisional Credentialed Status. If a new or renewal applicant is found deficient in one (1) or more of the requirements for credentialing, but does not have deficiencies that jeopardize the health and safety of the participants or substantially affect the provider's ability to provide services, a provisional credential may be issued. Provisional credentials will be issued for a period not to exceed one hundred eighty (180) days. During that time, the Department will determine whether the deficiencies have been corrected. If so, then the agency will be credentialed. If not, then the credential will be denied or revoked. (3-30-07)

09. Denial or Revocation of Credentialed Status. The Department may deny or revoke credentials when conditions exist that endanger the health, safety, or welfare of any participant or when the agency is not in substantial compliance with these rules. Additional causes for denial or revocation of credentials include the following: (5-8-09)

a. The provider agency or provider agency applicant has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining credentialed status; (3-30-07)

b. The provider agency or provider agency applicant has been convicted of fraud, gross negligence, abuse, assault, battery or exploitation; (5-8-09)

c. The provider agency or provider agency applicant has been convicted of a criminal offense within the past five (5) years other than a minor traffic violation or similar minor offense; (3-30-07)

d. The provider agency or provider agency applicant has been denied or has had revoked any health facility license or certificate; (3-30-07)

e. A court has ordered that any provider agency owner or provider agency applicant must not operate a health facility, residential care or assisted living facility, or certified family home; (3-30-07)

f. Any owners, employees, or contractors of the provider agency or provider agency applicant are listed on the statewide Child Abuse Registry, Adult Protection Registry, Sexual Offender Registry, or Medicaid exclusion lists; (3-30-07)

g. The provider agency or provider agency applicant is directly under the control or influence, whether financial or other, of any person who is described in Subsections 712.09.a. through 712.09.f. of this rule. (3-30-07)

10. Procedure for Appeal of Denial or Revocation of Credentials. Immediately upon denial or revocation of credentials, the Department will notify the applicant or provider in writing by certified mail or by personal service of its decision, the reason for its decision, and how to appeal the decision. The appeal is subject to the hearing provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-30-07)