IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.18 - MEDICAID COST-SHARING

DOCKET NO. 16-0318-1101 (FEE RULE)

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates for these temporary rules are November 1, 2011, and January 1, 2012.

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), and 56-257, Idaho Code.

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

Wednesday, October 12, 2011 6:00 p.m. (Local)	Tuesday, October 18, 2011 6:00 p.m. (Local)	Tuesday, October 18, 2011 6:00 p.m. (Local)
Health & Welfare Region VII **150 Shoup Ave** **2nd Floor Conf. Rm.** **Idaho Falls, ID**	**Health & Welfare Region IV** **1720 Westgate Drive** **Suite A Rm. 131** **Boise, ID**	**Health & Welfare Region I** **1120 Ironwood Drive** **Suite 102, Large Conf. Rm.** **Coeur d'Alene, 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:

The 2011 Legislature adopted HB 260 that directs the Department to establish, within the federal limitations of Medicaid law and regulations, enforceable cost sharing in the form of copayments to increase the awareness and responsibility of Medicaid participants for the cost of their health care. This docket provides language regarding when copayments can be charged for participants accessing the following services: chiropractic, podiatry, optometry, physical therapy, occupational therapy, speech therapy, physician office visits, and outpatient hospital services.

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:

These temporary rules are needed to assist Medicaid in meeting budgetary constraints and to meet statutory changes effective July 1, 2011, for the implementation of copayments for Medicaid health care assistance.

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:

Implementation of these copayments is estimated to be an annual cost savings to the Trustee and Benefits (T&B) of $750,000 in state general funds which was included in the Department's SFY 2012 appropriation.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because of the legislative intent language in House Bill 260 adopted by the 2011 Legislature.

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 Robin Pewtress at (208) 364-1892.

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 22nd day of August, 2011.

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THE FOLLOWING IS THE TEMPORARY RULE & PROPOSED TEXT OF DOCKET NO. 16-0318-1101

000. LEGAL AUTHORITY.
Under Section 56-202(b), Idaho Code, the Legislature has delegated to the Department of Health and Welfare the responsibility to establish and enforce such rules as may be necessary or proper to administer public assistance programs within the state of Idaho. Under Sections ~~*56-239 and 56-240*~~ 56-253 and 56-257, Idaho Code, ~~*the Idaho Legislature has authorized the Department of Health and Welfare to define program requirements and eligibility conditions for federal financial assistance in medical assistance programs*~~ is to establish enforceable cost-sharing requirements within the limits of federal medicaid law and regulations. Furthermore, the Idaho Department of Health and Welfare is the designated agency to administer programs under Title XIX and Title XXI of the Social Security Act. ~~*(3-19-07)*~~(11-1-11)T

001. TITLE, ~~*AND*~~ SCOPE, AND POLICY.

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

02. Scope. (11-1-11)T

a. ~~*Under Sections 56-239 and 56-240, Idaho Code, t*~~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. (11-1-11)T

b. This chapter does not apply to participants receiving benefits under IDAPA 16.03.16, "Premium Assistance." ~~*(3-19-07)*~~(11-1-11)T

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)

010. DEFINITIONS.

01. Copayment (Copay). The amount a participant is required to pay to the provider for specified services. (3-19-07)

02. Cost-Sharing. A payment the participant or the financially responsible adult is required to make toward the cost of the participant's health care. Cost-sharing includes both copays and premiums. (3-29-10)

03. Creditable Health Insurance. Creditable health insurance is coverage that provides benefits for inpatient and outpatient hospital services and physicians' medical and surgical services. Creditable coverage excludes liability, limited scope dental, vision, specified disease or other supplemental-type benefits. (3-29-10)

04. Department. The Idaho Department of Health and Welfare, or a person authorized to act on behalf of the Department. (3-19-07)

05. Family Income. The gross income of all financially responsible adults who reside with the participant, as calculated under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." (3-29-10)

06. Family Size. Family size is the number of people living in the same home as the child. This includes relatives and other optional household members. (3-29-10)

07. Federal Poverty Guidelines (FPG). The federal poverty guidelines issued annually by the U. S. Department of Health and Human Services (HHS). The federal poverty guidelines are available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. (3-29-10)

08. Financially Responsible Adult. An individual who is the biological or adoptive parent of a child and is financially responsible for the participant. (3-29-10)

09. 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. (3-19-07)

10. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-19-07)

11. Physician Office Visit. Services performed by a physician, nurse practitioner or physician's assistant at the practitioner's place of business, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Indian Health Clinic/638 Clinics providing services to individuals eligible for Indian Health Services are not included. (1-1-12)T

1~~1~~2. Premium. A regular and periodic charge or payment for health coverage. (4-6-05)

1~~2~~3. Social Security Act. 42 U.S.C. 101 et seq., authorizing, in part, federal grants to the states for medical assistance to eligible low-income individuals. (3-19-07)

1~~3~~4. State. The state of Idaho. (4-6-05)

1~~4~~5. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-29-10)

1~~5~~6. Title XXI. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-29-10)

011. -- 024. (RESERVED)

025. PARTICIPANTS EXEMPT FROM COST-SHARING.
Native American and Alaskan Native participants are exempt from the cost-sharing provisions of Sections 200, 205, 215, and 3~~0~~20 of these rules. The participant must declare his race to the Department to receive this exemption.
~~(3-29-10)~~(11-1-11)T

026. -- 049. (RESERVED)

050. GENERAL COST-SHARING.

01. Cost-Sharing Maximum Amount. A family will be required to pay out of pocket costs not to exceed five percent (5%) of the family's anticipated gross ~~*quarterly*~~ monthly income unless an exception is made as provided in Subsection 050.02 of this rule. ~~(3-26-08)~~(11-1-11)T

02. Exception to Cost-Sharing Maximum. A family will be required to pay cost-sharing amounts as provided in Sections 215 and 400 of these rules. These cost-sharing amounts may exceed the family's five percent (5%) of anticipated gross ~~*quarterly*~~ monthly income. ~~(3-26-08)~~(11-1-11)T

03. Proof of Cost-Sharing Payment. ~~*A family that has*~~ If a participant believes that his cost-sharing exceeded the five percent (5%) cost-sharing of the family's anticipated gross ~~*quarterly*~~ monthly income, he must provide proof to the Department of the copay amounts ~~*incurred*~~ that were paid. ~~(3-26-08)~~(11-1-11)T

04. Excess Cost-Sharing. A family that establishes proof of payment for cost-sharing that exceeds the five percent (5%) of the family's anticipated gross ~~*quarterly*~~ monthly income will be reimbursed by the Department for the amount paid that exceeds the five percent (5%), except as provided in Subsection 050.02 of this rule.
~~(3-26-08)~~(11-1-11)T

05. Cost-Sharing Suspended. A family that exceeds the five percent (5%) maximum amount for cost-sharing will not be required to pay a cost-sharing portion for any family participant for the remainder of the calendar ~~*quarter*~~ month in which proof of payment is established. ~~(3-26-08)~~(11-1-11)T

(BREAK IN CONTINUITY OF SECTIONS)

300. PARTICIPANTS EXEMPT FROM COPAYMENT~~S FOR MEDICAID SERVICES~~.
~~*Medicaid participants are responsible for making copayments for the following services under the following circumstances in Subsections 300.01 and 300.02 of this rule.*~~ ~~*(3-26-08)*~~

~~***01. Accessing Hospital Emergency Department for Non-Emergency Medical Conditions**. A participant who seeks care at a hospital emergency department for services that do not meet the definition of an emergency medical condition as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," may be required to pay a copayment to the provider. The amount of the copayment is provided in Section 310 of these rules. A participant who must access a hospital emergency department in order to receive routine services for his medical condition is exempt from this provision.* ~~*(3-26-08)*~~

0~~2~~1. ~~***Accessing Emergency Transportation Services for Non-Emergency Medical Conditions**. A participant who accesses emergency transportation services for a condition that is determined by the Department to be a non-emergency medical condition may be required to pay a copayment to the provider of the service. The amount of the copayment is provided in Section 310 of these rules. Certain participants are exempt from this copayment.*~~ **Exempt Participants**. Certain participants are exempt from copayments for services described in Section 320.02 through 320.10 of these rules. Exempt participants ~~*are*~~ include: ~~(3-26-08)~~(11-1-11)T

a. A child under the age of nineteen (19) with family income less than or equal to one hundred and thirty-three percent (133%) of the current federal poverty guidelines (FPG); (3-26-08)

b. An individual age of nineteen (19) or older with family income less than or equal to one hundred

percent (100%) of the current federal poverty guidelines (FPG); (11-1-11)T

~~b~~c. A pregnant or post-partum woman when the ~~medical condition for the needed transportation is~~ services provided are related to the pregnancy; ~~(3-26-08)~~(11-1-11)T

~~c~~d. An inpatient in a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities (ICF/ID), or other medical institution, who is required to pay all but a nominal amount of his income to the institution for his care; (3-26-08)

e. A participant who qualifies for services provided under a waiver of Section 1915c of the Social Security Act (SSA); (11-1-11)T

~~d~~f. A ~~Medicare beneficiary, whose Medicaid benefits consist of assistance with his Medicare cost-sharing obligations~~ participant who has other health care coverage that is the primary payor for the services provided; ~~(3-26-08)~~(11-1-11)T

~~e~~g. A participant receiving hospice care; (3-26-08)

~~f~~h. A child in foster care receiving aid or assistance under the Social Security Act (SSA), Title IV, Part B; (3-26-08)

~~g~~i. A participant receiving adoption or foster care assistance under the Social Security Act (SSA), Title IV, Part E, regardless of age; and (3-26-08)

~~h~~j. A woman eligible under the breast and cervical cancer eligibility group. (3-26-08)

02. **Notification of Copayment**. The Department will provide notification to each participant who is not exempt from the copayment requirements in Subsections 320.02 through 320.10 of these rule. (11-1-11)T

301. -- 309. (RESERVED)

310. COPAYMENT FEE AMOUNTS.

01. Nominal Amount. The amount of the copayment must be a nominal amount as provided in 42 CFR 447.54. This nominal amount is set by the U.S. Department of Health and Human Services. (3-26-08)

02. Fee Amount. Beginning on ~~February 1, 2007~~ November 1, 2011, the nominal fee amount required to be paid by the participant as a copayment is three dollars and sixty-five cents ($3.65). This copayment amount will be adjusted annually as determined by the Secretary of Human Services. ~~(3-26-08)~~(11-1-11)T

03. Annual Increase. The nominal fee amount will be increased annually by an adjusted percentage rate determined by the Secretary of Health and Human Services as set in the Social Security Act Section 1916. (3-26-08)

311. -- 3~~0~~19. (RESERVED)

320. MEDICAID SERVICES SUBJECT TO COPAYMENTS.
Medicaid participants are responsible for making copayments for the services described in Subsections 320.01 through 320.10 of this rule, unless exempted. The amount of the copayment is provided in Section 310 of these rules. (11-1-11)T

01. **Accessing Hospital Emergency Department for Non-Emergency Medical Conditions**. A participant who seeks care at a hospital emergency department for services that do not meet the definition of an emergency medical condition as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," may be required to pay a copayment to the provider. A participant who must access a hospital emergency department in order to receive routine services for his medical condition is exempt from this provision. (11-1-11)T

02. Accessing Emergency Transportation Services for Non-Emergency Medical Conditions. A participant who accesses emergency transportation services for a condition that is determined by the Department to be a non-emergency medical condition may be required to pay a copayment to the provider of the service. (11-1-11)T

03. Chiropractic Services. Those services for spinal manipulation performed by a chiropractor. (11-1-11)T

04. Occupational Therapy. (1-1-12)T

05 Optometric Services. Those services performed by a optometrist that fall into the "General Ophthalmological Services" category of Current Procedural Terminology (CPT). (11-1-11)T

06. Outpatient Hospital Services. Any of the services included in Subsections 320.03 through 320.05 and Subsections 320.07 through 320.10 of this rule performed in an outpatient hospital setting. Services performed in a Hospital Emergency Department are excluded, except as provided for in Subsection 320.01 of this rule. (1-1-12)T

07. Physical Therapy. (1-1-12)T

08. Podiatry Services. Services provided by a podiatrist during an office visit. (11-1-11)T

09. Physician Office Visit. Each physician office visit, unless the visit is for a preventive wellness exam, immunizations, or family planning. (1-1-12)T

10. Speech Therapy. (1-1-12)T

321. -- 324. (RESERVED)

325. EXCEPTION TO CHARGING A COPAYMENT.
In order for a copay to be charged by the provider, the Medicaid payment amount for the services rendered during a visit must be equal to or greater than ten (10) times the amount of the copay described in Section 310 of these rules. The Medicaid payment amount is determined by the Department and published in the Medicaid Fee Schedule. (11-1-11)T

326. -- 329. (RESERVED)

330. COLLECTION OF COPAYMENTS.

01. Responsibility for Collection. The provider of services is responsible for collection of the copayment from the participant. (11-1-11)T

02. Denial of Services. The provider may require payment of an applicable copay prior to rendering services. (11-1-11)T

03. Waiver of Copayment. The provider may choose to waive payment of any copay. The provider must have a written policy describing the criteria for enforcing collection of copayments and when the copay may be waived. (11-1-11)T

04. Reduction in Reimbursement.When a copay is applicable, the provider's reimbursement will be reduced by the amount of the copay regardless of whether or not a copay was charged or collected by the provider. (11-1-11)T

331. -- 399. (RESERVED)