IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1201

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:

Wednesday - October 24, 2012
1:00 p.m. MDT

Medicaid Central Office
Conference Room East
3232 Elder Street
Boise, ID 83705

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 a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The 2012 Legislature requested the Department work with providers to determine an effective process for reporting and providing information in an effective manner for evaluation of provider rates of reimbursement set by Medicaid that is not already based on another established rate methodology. These proposed rules provide a process for providers to report costs incurred and for the Department to determine rates based on those reports.

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

The changes in this rulemaking are meant to be budget neutral and have no fiscal impact to the state general fund.

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 May 2, 2012, Idaho Administrative Bulletin, Vol. 12-5, page 71.

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 proposed rule, contact Sheila Pugatch at (208) 364-1817.

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 24, 2012.

DATED this 29th day of August, 2012.

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THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0310-1201

036. GENERAL REIMBURSEMENT.

01. Long-Term Care Facility Payment. Long-term care facilities will be reimbursed the lower of their customary charges, their actual reasonable costs, or the standard costs for their class as set forth in the Provider Reimbursement Manual, but the upper limits for payment must not exceed the payment which would be determined as reasonable costs using the Title XVIII Medicare standards and principles. (3-19-07)

02. Individual Provider Payment. The Department will not pay the individual provider more than the lowest of: (3-19-07)

a. The provider's actual charge for service; or (3-19-07)

b. The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or (3-19-07)

c. The Medicaid upper limitation of payment on those services, minus the Medicare payment, where a participant is eligible for both Medicare and Medicaid. The Department will not reimburse providers an amount in excess of the amount allowed by Medicaid, minus the Medicare payment. (3-19-07)

~~***03. Payment for Therapy Services.*** *The fees for physical therapy, occupational therapy, and speech-language pathology services include the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the client for the use of such equipment.* ***(4-2-08)***~~

~~***037. 038. (RESERVED)***~~

037. GENERAL REIMBURSEMENT: PARTICIPANT SERVICES.
The Department will evaluate provider reimbursement rates that comply with 42 U.S.C. 1396a(a)(30)(A). This evaluation will assure payments are consistent with efficiency, economy, and quality of care and safeguards against unnecessary utilization of care and services. Reimbursements will be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. ( )

01. Review Reimbursement Rates. The Department will review provider reimbursement rates and conduct cost surveys when an access or quality indicator reflects a potential access or quality issue described in Subsections 037.02 and 037.03 of this rule. ( )

02. Access. The Department will review annual statewide and regional access reports by service type comparing the previous twelve (12) months to the base-line year of State Fiscal Year 2012. The following measures will be used to determine when there is potential for access issues. ( )

a. Compare the change in total number of provider locations for service type to the change in eligible participants; or ( )

b. When participant complaints and critical incidence logs reveal outcomes that identify access issues for a service type. ( )

03. Quality. The Department will review quality reports required by each program used to monitor for patterns indicating an emerging quality issue. ( )

04. Cost Survey. The Department will survey one hundred percent (100%) of providers. Cost surveys

are unaudited, but providers that refuse or fail to respond to the periodic state surveys may be disenrolled as a Medicaid provider. The Department will derive reimbursement rates using direct care staff costs, employment related expenditures, program related costs, and indirect general and administrative costs in the reimbursement methodology, when these costs are incurred by a provider. The Department will conduct cost surveys customized for each of the services defined in Section 038 of these rules. ( )

a. Wage rates will be used in the reimbursement methodology when the expenditure is incurred by the provider type executing the program. Wages will be identified in the Bureau of Labor Statistics website at www.bls.gov when there is a comparable occupation title for the direct care staff. When there is no comparable occupation title for the direct care staff, then a weighted average hourly rate methodology will be used. ( )

b. For employer related expenditures: ( )

i. The Bureau of Labor Statistics's report for employer costs per hour worked for employee compensation and costs as a percent of total compensation for Mountain West Divisions will be used to determine the incurred employer related costs by each provider type. The website for access to this report is at www.bls.gov. ( )

ii. The Internal Revenue Service employer cost for social security benefit and Medicare benefit will be used to determine the incurred employer related costs by provider type. The website for access to this information is at www.irs.gov. ( )

c. Cost surveys to collect indirect general, administrative, and program related costs will be used when these expenditures are incurred by the provider type executing the program. The costs will be ranked by costs per provider, and the Medicaid cost used in the reimbursement rate methodology will be established at the seventy-fifth percentile in order to efficiently set a rate. ( )

038. GENERAL REIMBURSEMENT: TYPES OF PARTICIPANT SERVICES.
The following types of services are reimbursed as provided in Section 037 of these rules. ( )

01. Payment for Enhanced Outpatient Mental Health Services. The fees for outpatient mental health services described in Section 110 of these rules. ( )

02. Psychosocial Rehabilitative Services (PSR). The fees for psychosocial rehabilitative services (PSR) described in Section 120 of these rules. ( )

03. Personal Care Services. The fees for personal Care Services (PCS) described in Section 300 of these rules. ( )

04. Aged and Disabled Waiver Services. The fees for personal care services (PCS) described in Section 320 of these rules. ( )

05. Children's Waiver Services. The fees for children's waiver services described in Section 680 of these rules. ( )

06. Adults with Developmental Disabilities Waiver Services. The fees for adults with developmental disabilities waiver services described in Section 700 of these rules. ( )

07. Service Coordination. The fees for service coordination described in Section 720 of these rules. ( )

08. Therapy Services. The fees for physical therapy, occupational therapy, and speech-language pathology services described in Section 215 of these rules include the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the client for the use of such equipment. ( )

(BREAK IN CONTINUITY OF SECTIONS)

307. PERSONAL CARE SERVICES: PROVIDER REIMBURSEMENT.

01. Reimbursement Rate. Personal assistance providers will be paid a uniform reimbursement rate for service as established by the Department ~~*on an annual basis*~~. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department.
~~*(3-21-12)*~~( )

02. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical transportation, unless approved by the ~~*RMS*~~ Department or its contractor under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as provided in Subsections 307.03 through 307.0~~7~~8 of ~~*these*~~ this rule~~s~~.
~~*(3-19-07)*~~( )

03. Weighted Average Hourly Rate~~s~~ Methodology. Annually Medicaid will conduct a poll of all Idaho nursing facilities and ICFs/ID, and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, certified and non-certified nurse's aides) in Idaho to be used in calculating the reimbursement rate to be effective on July 1st of that year.
~~*(3-29-10)*~~( )

04. Payment for Personal Assistance Agency. Payment for personal assistance agency services will be paid according to rates established by the Department.
~~*(3-4-11)*~~( )

a. The Department will establish Personal Assistance Agency rates for personal assistance services based on the WAHR. ~~*For State Fiscal Year 2012, this rate will only be adjusted if the prevailing hourly rate for comparable positions is less than the rate paid during State Fiscal Year 2011.*~~

Personal Assistance Agencies	WAHR x supplemental component	=	$ amount/hour

~~*(3-21-12)*~~( )

b. ~~*Beginning with State Fiscal Year 2013, every five (5) years the Department will conduct a survey of all Personal Assistance Agencies which requests the number of hours of all Direct Care Staff and the costs involved for all travel, administration, training, and all payroll taxes and fringe benefits. Based on the survey conducted, t*~~The Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year.
~~*(3-21-12)*~~( )

c. ~~*Based on the survey conducted, provided that at least eighty-five percent (85%) of all Personal Assistance Agencies respond, the Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. If less than eighty-five percent (85%) of all Personal Assistance Agencies respond, the rate will remain at the WAHR rate without the supplemental component.*~~ The Department will survey one hundred percent (100%) of personal care service providers. Cost surveys are unaudited, but a provider that refuses or fails to respond to the periodic state surveys may be disenrolled as a Medicaid provider. The Department will derive reimbursement rates using direct care staff costs, employment related expenditures, program related costs, and indirect general and administrative costs in the reimbursement methodology, when these costs are incurred by a provider.
~~*(3-4-11)*~~( )

05. Payment Levels for Adults in Residential Care or Assisted Living Facilities or Certified Family Homes. Adult participants living in Residential Care or Assisted Living Facilities (RCALF) or Certified Family Homes will receive personal care services at a rate based on their care level. Each level will convert to a specific number of hours of personal care services. (3-19-07)

a. Reimbursement Level I -- One point twenty-five (1.25) hours of personal care services per day or eight point seventy-five (8.75) hours per week. (3-19-07)

b. Reimbursement Level II -- One point five (1.5) hours of personal care services per day or ten point five (10.5) hours per week. (3-19-07)

c. Reimbursement Level III -- Two point twenty-five (2.25) hours of personal care services per day or fifteen point seventy-five (15.75) hours per week. (3-19-07)

d. Reimbursement Level IV - One point seventy-nine (1.79) hours of personal care services per day or twelve point five (12.5) hours per week. This level will be assigned based on a documented diagnosis of mental illness, intellectual disability, or Alzheimer's disease. If an individual is assessed as Level III with a diagnosis of mental illness, intellectual disability, or Alzheimer's disease the provider reimbursement rate will be the higher amount as described in Subsection 307.05.c. of these rules. (3-19-07)

06. Attending Physician Reimbursement Level. The attending physician or authorized provider will be reimbursed for services provided using current payment levels and methodologies for other services provided to eligible participants. (3-19-07)

07. Supervisory RN and QMRP Reimbursement Level. The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Participant evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the ~~*RMS*~~ Department or its contractor. ~~*(3-19-07)*~~( )

a. The number of supervisory visits by the RN or QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the ~~*RMS*~~ Department or its contractor. ~~*(3-19-07)*~~( )

b. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the ~~*RMS*~~ Department or its contractor. ~~*(3-19-07)*~~( )

08. Payment for PCS Family Alternate Care Home. The Department will establish PCS Family Alternate Care Home rates for personal assistance services based on the WAHR. ~~*Beginning with State Fiscal Year 2013, every five (5) years the Department will conduct a survey of all Personal Assistance Agency's which requests the number of hours of all Direct Care Staff and the indirect costs involved such as administration, and training.*~~ Based on the survey conducted, the Department will calculate a supplemental component using costs reported for administration, and training. The survey data is the cost information collected during the prior State Fiscal Year.

PCS Family Alternate Care Home	Children's PCS Assessment Weekly Hours x (WAHR x supplemental component)	=	$ amount/week

~~*(3-21-12)*~~( )