# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.03.09 - MEDICAID BASIC PLAN BENEFITS

## DOCKET NO. 16-0309-1302

## 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; also 42 CFR 447.90 - Credible allegations of fraud; 42 CFR 455 - Provider Screening and Enrollment; and 42 CFR 498 - Appeal rights; and Subtitle E, Section 6401 of the Patient Protection and Affordable Care Act (Affordable Care Act).

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

| **Tuesday, October 15, 2013 at 2:00 p.m. MDT** |
|---|
| **Medicaid Central Office**<br>**Conference Room D-East**<br>**3232 Elder St, Boise, ID** |
| You may also participate in this hearing via conference call:<br>Call-in Number: **1-888-706-6468**<br>When prompted, enter Participant ID: **8617015** |

| **Thursday, October 17, 2013 at 2:00 p.m. MDT** |
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| **IDHW Region VI Office**<br>**2nd Floor Conf. Room**<br>**1070 Hiline Road**<br>**Pocatello, ID** |

| **Friday, October 18, 2013 at 2:00 p.m. PDT** |
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| **IDHW Region I Office**<br>**Suite 102, (lower level large conference room)**<br>**1120 Ironwood Drive**<br>**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 a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The proposed rule changes are being done to align with changes in federal regulations and to comply with CMS requirements related to missed appointments.

The proposed rule changes will align state rules with federal regulations in 42 CFR 447.90, 42 CFR 455, and 42 CFR 498 that require the Medicaid agency to:

1. Re-validate all provider enrollment information no less frequently than every five (5) years;
2. Ensure all providers prescribing drugs or ordering services for Medicaid participants are enrolled with the agency;
3. Ensure that all providers complete a screening process involving site visits and payment of fees for certain types of providers, either through the Medicaid agency itself or through Medicare; and
4. Align the appeals process for providers denied enrollment with federal requirements.

This rule change will also clarify language about provider charges for missed appointments in accordance with federal requirements.

**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: NA

**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:

These changes will be accomplished with existing resources and modifications to existing operational processes and are expected to be cost neutral.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because it was not feasible due to the fact that these rule changes are being done to comply with federal requirements under 42 CFR. The Department has selected the means of compliance that are the least burdensome and the least costly to both providers and the state.

**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 Jeanne Siroky at (208) 364-1897.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2013.

DATED this 30th day of August, 2013.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
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**THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0309-1302**

**160. RESPONSIBILITY FOR KEEPING APPOINTMENTS.**
The participant is solely responsible for making and keeping an appointment with the provider. ~~*If a participant makes an appointment and subsequently does not keep it, the participant may be required to pay the provider an amount established by the provider's missed appointment policy that is applicable to all patients of the provider.*~~ The

Department will not reimburse providers when participants do not attend scheduled appointments. Providers may not bill participants for missed appointments. ~~(4-2-08)~~( )

*(BREAK IN CONTINUITY OF SECTIONS)*

**200. PROVIDER APPLICATION PROCESS.**

**01. Provider Application**. ~~*Providers may apply for provider numbers with the Department. Those in-state providers who have previously been assigned a Medicare number may retain that same number. The Department will confirm the status for all applicants with the appropriate licensing board and assign Medicaid provider numbers.*~~ Providers who meet Medicaid enrollment requirements may apply for Idaho Medicaid provider status with the Department. All healthcare providers who are eligible for a National Provider Identifier (NPI) must apply using that identifying number. For providers not eligible for a NPI, the Department will assign a provider number upon approval of the application. ~~(3-30-07)~~( )

**02. ~~Denial of Provider Application~~ Screening Levels**. ~~*The Department must not accept the application of a provider who is suspended from Medicare or Medicaid in another state.*~~ In accordance with 42 CFR 455.450, the Department will assign risk levels of "limited," "moderate," or "high" to defined groups of providers. These assignments and definitions will be published in the provider handbook. ~~(3-30-07)~~( )

**03. Medicare Enrollment Requirement for Specified Providers**. The following providers must enroll as Medicare providers prior to enrollment or revalidation as a Medicaid provider. ( )

**a.** Any providers classified in the "moderate" or "high" categorical risk level, as defined in the provider handbook. ( )

**b.** Any provider type classified as an institutional provider by Medicare. ( )

**04. Disclosure of Information by Providers and Fiscal Agents**. All enrolling providers and their fiscal agents must comply with the disclosure requirements as stated in 42 CFR 455, Subpart B, "Disclosure of Information by Providers and Fiscal Agents." ( )

**05. Denial of Provider Agreement**. The Department may deny provider status by refusing a request to enter into a provider agreement, refusing to extend an existing agreement, or refusing to enter into additional agreements with any individual or entity. Reasons for denying provider status include those described in IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct," Section 265. ( )

**06. Mandatory Denial of Provider Agreement**. The Department will deny a request for a provider agreement when: ( )

**a.** The provider fails to meet the qualifications required by rule or by any applicable licensing board; ( )

**b.** The provider was a managing employee, or had an ownership interest, as defined in 42 CFR Section 455.101, in any entity that was previously found by the Department to have engaged in fraudulent conduct, or abusive conduct related to the Medicaid program, or has demonstrated an inability to comply with the requirements related to the provider status for which application is made, including submitting false claims or violating provisions of any provider agreement; ( )

**c.** The provider was a managing employee, or had an ownership interest, as defined in 42 CFR Section 455.101, in any entity that failed to repay the Department for any overpayments, or to repay claims previously found by the Department to have been paid improperly, whether the failure resulted from refusal, bankruptcy, or otherwise, unless prohibited by law; ( )

**d.** The provider employs as a managing employee, contracts for any management services, shares any ownership interests, or would be considered a related party to any individual or entity identified in Subsections 200.06.a. through 200.06.c. of this rule. ( )

**e.** The provider fails to comply with any applicable requirement under 42 CFR 455. ( )

**f.** The provider is precluded from enrollment due to a temporary moratorium issued by the Secretary of Health and Human Services in accordance with 42 CFR 455.470. ( )

**g.** The provider is currently suspended from Medicare or Medicaid in any state, or has been terminated from Medicare or Medicaid in any state. ( )

**201. -- 204. (RESERVED)**

**205. AGREEMENTS WITH PROVIDERS.**

**01. In General**. ~~*The Department will enter into written agreements with each provider or group of providers of supplies or services under the Program.*~~ All individuals or organizations must enter into a written provider agreement accepted by the Department prior to receipt of any reimbursement for services. Agreements may contain any terms or conditions deemed appropriate by the Department. ~~*Each agreement will contain, among others, the following terms and conditions requiring the provider:*~~ All provider agreements must be signed by the provider or by an owner or officer who has the legal authority to bind the provider in the agreement. ~~*(3-30-07)*~~( )

~~***a.*** *To retain for a minimum of six (6) years any records necessary for a determination of the services the provider furnishes to participants; and* *(3-30-07)*~~

~~***b.*** *To furnish to the Department, the U.S. Department of Health and Human Services, the Fraud Investigation Unit, or the Idaho State Police any information requested regarding payments claimed by the provider for services; and* *(3-30-07)*~~

~~***c.*** *To furnish to the Department, the U.S. Department of Health and Human Services, the Fraud Investigation Unit, or the Idaho State Police, information requested on business transactions as follows:* *(3-30-07)*~~

~~*i.* *Ownership of any subcontractor with whom the provider has had business transactions of more than twenty-five thousand dollars ($25,000) during a twelve (12) month period ending on the date of request; and* *(3-30-07)*~~

~~*ii.* *Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the five (5) year period ending on the date of request.* *(3-30-07)*~~

**02. Federal Disclosure Requirements**. To comply with the disclosure requirements in 42 CFR 455, Subpart B, each provider, other than an individual practitioner or a group of practitioners, must disclose to the Department: (3-30-07)

**a.** The full name and address of each individual who has either direct or indirect ownership interest in the disclosing entity or in any subcontractor of five percent (5%) or more prior to entering into an agreement or at the time of survey and certification; and (3-30-07)

**b.** Whether any person named in the disclosure is related to another person named in the disclosure as a spouse, parent, or sibling. (3-30-07)

**03. ~~*Termination of*~~ Provider Agreement~~*s*~~ Enforcement Actions and Terminations**. Provider agreements may be terminated with or without cause. Terminations for cause may be appealed as a contested case in accordance with the IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." The Department may, at its discretion, take any of the following actions for cause based on the provider's conduct or the conduct of its employees or agents, or when the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation: ~~*(3-30-07)*~~( )

**a.** ~~*The Department may, in its discretion, terminate a provider's agreement for cause based on its conduct or the conduct of its employees or agents, when the provider fails to comply with any term or provision of the provider agreement. Other action may also be taken, based on the conduct of the provider as provided in Section 205 of this chapter of rules, and notice of termination must be given as provided therein. Terminations for cause may be appealed as a contested case in accordance with the IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Ruling."*~~ Require corrective actions as described in IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct," Section 270. ~~*(3-30-07)*~~( )

**b.** Require a corrective action plan to be submitted by the provider to address noncompliance with the provider agreement; ( )

**c.** Reduce, limit, or suspend payment of claims pending the submission, acceptance, or completion of a corrective action plan; ( )

**d.** Limit or suspend provision of services to participants who have not previously established services with the provider pending the submission, acceptance, or completion of a corrective action plan; or ( )

**e.** Terminate the provider's agreement. ( )

~~***b***~~**04. Termination of Provider Agreements**. Due to the need to respond quickly to state and federal mandates, as well as the changing needs of the State Plan, the Department may terminate provider agreements without cause by giving written notice to the provider as set forth in the agreement. If an agreement does not provide a notice period, the period is twenty-eight (28) days. Terminations without cause may result from, but are not limited to, elimination or change of programs or requirements, or the provider's inability to continue providing services due to the actions of another agency or board. Terminations without cause are not subject to contested case proceedings since the action will either affect a class of providers, or will result from the discretionary act of another regulatory body. ~~*(3-30-07)*~~( )

~~***04. Denial of Provider Agreement.*** *The Department may deny provider status by refusing a request to enter into a provider agreement, refusing to extend an existing agreement, or refusing to enter into additional agreements with any individual or entity, that:* *(3-30-07)*~~

~~***a.*** *Fails to meet the qualifications required by rule or by any applicable licensing board;* *(3-30-07)*~~

~~***b.*** *Has previously been, or was a managing employee, or had an ownership interest, as defined in 42 C.F.R Section 455.101, in any entity which was previously found by the Department to have engaged in fraudulent conduct, or abusive conduct related to the Medicaid program or has demonstrated an inability to comply with the requirements related to the provider status for which application is made, including, but not limited to submitting false claims or violating provisions of any provider agreement;* *(3-30-07)*~~

~~***c.*** *Has failed, or was a managing employee, or had an ownership interest, as defined in 42 C.F.R Section 455.101, in any entity that failed to repay the Department for any overpayments, or to repay claims previously found by the Department to have been paid improperly, whether the failure resulted from refusal, bankruptcy, or otherwise, unless prohibited by law; or* *(3-30-07)*~~

~~***d.*** *Employs as a managing employee, contracts for any management services, shares any ownership interests, or would be considered a related party to any individual or entity identified in Subsections 205.04.a. through 205.04.c., of this rule.* *(3-30-07)*~~

**206. -- 209. (RESERVED)**

**210. CONDITIONS FOR PAYMENT.**

**01. Participant Eligibility**. The Department will reimburse providers for medical care and services, regardless of the current eligibility status of the medical assistance participant in the month of payment, provided ~~*that*~~ a complete and properly submitted claim for payment has been received and each of the following conditions are met:

~~(3-30-07)~~( )

**a.** The participant was found eligible for medical assistance for the month, day, and year during which the medical care and services were rendered; (3-30-07)

**b.** The participant received such medical care and services no earlier than the third month before the month in which application was made on such participant's behalf; and (3-30-07)

**c.** The provider verified the participant's eligibility on the date the service was rendered and can provide proof of the eligibility verification. ( )

~~e~~**d.** Not more than twelve (12) months have elapsed since the month of the latest participant services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. (3-30-07)

**02. Time Limits**. The time limit set forth in Subsection 210.01.~~e~~d. of this rule does not apply with respect to retroactive eligibility adjustment ~~*payments*~~. When participant eligibility is determined retroactively, the Department will reimburse providers for services within the period of retroactive eligibility if a claim for those services is submitted within twelve (12) months of the date of the participant's eligibility determination.
~~(3-30-07)~~( )

**03. Acceptance of State Payment**. By participating in the Medical Assistance Program, providers agree to accept, as payment in full, the amounts paid by the Department for services to Medicaid participants. Providers also agree to provide all materials and services without unlawfully discriminating on the grounds of race, age, sex, creed, color, national origin, or physical or intellectual disability. (3-30-07)

**04. Payment in Full**. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as full payment for that service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. (3-30-07)

**05. Medical Care Provided Outside the State of Idaho**. Out-of-state medical care is subject to the same utilization review and other Medicaid coverage requirements and restrictions as medical care received within the state of Idaho. (3-30-07)

**06. Ordering, Prescribing, and Referring Providers**. Any service or supply ordered, prescribed, or referred by a physician or other professional who is not an enrolled Medicaid provider will not be reimbursed by the Department. ( )

*(BREAK IN CONTINUITY OF SECTIONS)*

**342. --** ~~***349.***~~ ~~***(RESERVED)***~~

~~***350. CRITERIA FOR PARTICIPATION IN THE MEDICAID PROGRAM.***~~

~~***01. Application for Participation and Reimbursement.*** *Prior to participation in the Medicaid Program, the Department must certify a facility for participation in the Program. Their recommendations are forwarded to the Division of Welfare, Division of Medicaid or its successor organization, for approval. The Division of Medicaid or its successor organization issues a provider number to the facility which becomes the primary provider identification number. The Division of Medicaid or its successor organization will need to establish an interim rate for the new applicant facility. This facility is now authorized to offer services at the level for which the provider agreement was issued.*~~ ~~*(3-30-07)*~~

~~***02. Reimbursement.*** *The reimbursement mechanism for payment to providers that Medicaid reimburses under a cost-based methodology under Sections 300 through 389 of these rules. The Medical Assistance*~~

~~*Program will not reimburse a facility until it is certified, has a signed agreement for participation and an established interim per diem rate.*~~ ~~*(3-30-07)*~~

~~*351.*~~ **359. (RESERVED)**

***(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 ~~*identified by Medicare*~~ enrolled with Medicaid as independent practitioners~~,~~ and licensed by the appropriate state licensing board ~~*and enrolled as Medicaid providers*~~ will be reimbursed on a fee-for-service basis. ~~*Exceptions to the requirement for Medicare certification include:*~~ ~~*(5-8-09)*~~

~~*i. Provider types that Medicare does not certify as is the case for speech-language pathologists; and*~~ ~~*(5-8-09)*~~

~~*ii. Providers that only treat pediatric participants and do not expect to treat Medicare participants.*~~ ~~*(5-8-09)*~~

~~*iii.*~~ 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. ~~*(5-8-09)*~~( )

**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)