Dear Senators LODGE, Broadsword, Bock, and
Representatives MCGEACHIN, Bilbao, Rusche:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of the Department of Health and Welfare - Medicaid Cost-Sharing:

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1105);

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1106);

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1107);

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1108);

IDAPA 16.03.18 - Rules Pertaining To The Medicaid Cost-Sharing (Fee Rule) (Docket No. 16-0318-1101).

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 10/27/2011. 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 11/29/2011.

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 334-4845, or send a written request to the address or FAX number indicated on the memorandum enclosed.

Legislative Services Office
Idaho State Legislature

Jeff Youtz
Director

Serving Idaho's Citizen Legislature

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Health & Welfare Committee and the House Health & Welfare Committee

FROM: Legislative Research Analyst - Ryan Bush

DATE: October 7, 2011

SUBJECT: Department of Health and Welfare - Medicaid Cost-Sharing

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1105)

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1106)

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1107)

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1108)

IDAPA 16.03.18 - Rules Pertaining To The Medicaid Cost-Sharing (Fee Rule) (Docket No. 16-0318-1101)

(1) 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1105)

The Department of Health and Welfare submits notice of temporary and proposed rulemaking at IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits. The Department states that the proposed changes are being made to align the rules with House Bill 260 (2011) as codified in Section 56-255(3)(d), Idaho Code. Specifically, this rulemaking adds a requirement that mental health agency providers meet national accreditation standards.

The Department states that negotiated rulemaking was not conducted because the rulemaking is being done to bring this chapter of rules into compliance with House Bill 260 (2011). Public hearings concerning this rulemaking are scheduled on October 12, 2011 at 2:00 p.m. MDT, at the State Office Building in Idaho Falls, ID; on October 13, 2011 at 2:00 p.m. PDT, at the Health & Welfare Region I Lower Level Conf. Room in Couer d'Alene, ID; and on October 14, 2011 at 2:00 p.m. MDT, at the Medicaid Central Office in Boise, ID.

The proposed rule appears to be within the authority granted to the Department in Sections 56-202(b) and 56-253(8), Idaho Code.

(2) 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1106)

The Department of Health and Welfare submits notice of proposed rulemaking at IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits. The Department states that the proposed rulemaking is to align the rules with House Bill 165 (2011) as codified in Section 209p, Idaho Code, which requires the Department to pay for midwife services provided to eligible participants through the medical assistance program. Specifically, this rulemaking revises and adds to the definition of a midwife; adds certified professional midwife (CPM) services to the services covered under basic plan benefits; defines CPM services; provides for

participant eligibility; provides for CPM coverage and limitations; lists CPM qualifications and duties; provides for CPM reimbursement; and lists CPM quality assurance activities.

The Department states that negotiated rulemaking was not conducted because the rulemaking is in response to House Bill 165 (2011). A public hearing concerning this rulemaking is scheduled on October 20, 2011 at 6:00 p.m. MDT, at the Health and Welfare Region IV Office, 1720 Westgate Dr., Boise, ID. The Department states that the fiscal impact of this rulemaking is uncertain given the unknown number of participants who will choose to use CPM services.

The proposed rule appears to be within the authority granted to the Department in Sections 56-202(b) and 56-209p, Idaho Code.

(3) 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1107)

The Department of Health and Welfare submits notice of proposed rulemaking at IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits. The Department states that the proposed rulemaking is to align the rules with House Bill 260 (2011) as codified in Section 56-255(5)(a)(xi) and (xii), Idaho Code. Specifically, this rulemaking limits physical therapy, speech language pathology and occupational therapy services to align with annual Medicare gaps and authorizes additional services only when medically necessary and supported by documentation. The proposed rule also creates an exception to the service limitations.

The Department states that negotiated rulemaking was not conducted because the rulemaking is being done to bring this chapter of rules into compliance with House Bill 260 (2011). Public hearings concerning this rulemaking are scheduled on October 13, 2011, at 6:00 p.m. local time, at the Health and Welfare Region IV office in Boise, ID; on October 17, 2011, at 6:00 p.m. local time, at the Health and Welfare Region I office in Coeur d'Alene, ID; and on October 19, 2011, at 6:00 p.m. local time, at the Health and Welfare Region VII office in Idaho Falls, ID. The anticipated fiscal impact of this rulemaking will result in cost savings of $150,000 in state general funds for SFY 2012 and $300,000 for each subsequent year.

The proposed rule appears to be within the authority granted to the Department in Sections 56-202(b) and 56-253(8), Idaho Code.

(4) 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1108)

The Department of Health and Welfare submits notice of proposed rulemaking at IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits. The Department states that the proposed rulemaking is clarifying rules related to Medicaid's reimbursement policies to providers for non-Medicare coordination of benefits when a third party payor reimburses a provider for services or when the Department determines that third party liability exists. The Department further states that these policies are determined under the Centers for Medicare and Medicaid Services State Medicaid Manual.

The Department states that negotiated rulemaking was not conducted because this rulemaking is for clarification of current policies. There is no fiscal impact associated with this rulemaking.

The proposed rule appears to be within the authority granted to the Department in Section 56-202(b), Idaho Code.

(5) 16.03.18 - Rules Pertaining To The Medicaid Cost-Sharing (Fee Rule) (Docket No. 16-0318-1101)

The Department of Health and Welfare submits notice of temporary and proposed rulemaking at IDAPA 16.03.18 - Rules Pertaining To The Medicaid Cost-Sharing (Fee Rule). The Department states that the proposed rulemaking is to align the rules with House Bill 260 (2011) as codified in Section 56-257, Idaho Code. The

Department further states that the proposed rulemaking 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. The proposed rulemaking also revises legal authority; adds a definition; revises general cost-sharing criteria by looking to a family's gross monthly income rather than quarterly income; adds to and revises participants exempt from copayments; provides for notification and collection of copayments; and adds an exception to charging a co-payment. We note one typographical error in the revisions to legal authority. The revisions currently read as follows: "*Under Sections 56-253 and 56-257, Idaho Code, is to establish* enforceable cost-sharing requirements within the limits of federal medicaid law and regulations." (Italics added).

The Department states that negotiated rulemaking was not conducted because the rulemaking is being done to bring this chapter of rules into compliance with House Bill 260 (2011). Public hearings concerning this rulemaking are scheduled on October 12, 2011, at 6:00 p.m. local time, at the Health and Welfare Region VII office in Idaho Falls, ID; on October 18, 2011, at 6:00 p.m. local time, at the Health and Welfare Region IV office in Boise, ID; and on October 18, 2011, at 6:00 p.m. local time, at the Health and Welfare Region I office in Coeur d'Alene, ID. The Department estimates that the implementation of these copayments will result in an annual cost savings to the Trustees and Benefits of $750,000 in state general funds which was included in the Department's SFY 2012 appropriation.

The proposed rule appears to be within the authority granted to the Department in Sections 56-202(b) and 56-253(8), Idaho Code.

cc: Department of Health and Welfare - Medicaid Cost-Sharing
Tamara Prisock
Carolyn Burt
Jeanne Siroky
Robert Kellerman
Robin Pewtress

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
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5564; fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

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)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1106

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Sections 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), and 56-209p, Idaho Code.

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

Tuesday, October 20, 2011
6:00 p.m. (Local)

Health & Welfare Region VI
1720 Westgate Drive
Suite A Rm. 131
Boise, ID

The hearing sites 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 Section 56-209p, Idaho Code, the Department is required to pay for midwife services provided to eligible participants through the medical assistance program. Because system changes are needed to add this provider group for Certified Professional Midwife (CPM) Services and time is needed to enroll providers, these proposed rules will be implemented on January 1, 2012. The changes in this docket provide for the administration and policies needed to reimburse for CPM services.

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:

The anticipated fiscal impact due to this rulemaking is uncertain given the uncertainty of the number of participants who will choose to use Certified Professional Midwife (CPM) services.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation under HB 165.

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 Jeanne Siroky (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 26, 2011.

DATED this 8th day of September, 2011.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5564; fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0309-1106

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. 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)

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

04. 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)

05. 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)

06. 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)

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

08. 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)

09. 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)

10. 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)

11. **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)

12. **Medicaid**. Idaho's Medical Assistance Program. (3-30-07)

13. **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)

14. **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)

15. **Medical Supplies**. Items excluding drugs, biologicals, and equipment furnished incident to a physician's professional services commonly furnished in a physician's office or items ordered by a physician for the treatment of a specific medical condition. These items are generally not useful to an individual in the absence of an illness and are consumable, nonreusable, disposable, and generally have no salvage value. Surgical dressings, ace bandages, splints and casts, and other devices used for reduction of fractures or dislocations are considered supplies. (3-30-07)

16. **Midwife**. An individual qualified as one of the following: ( )

a. Nurse Midwife (NM). An advanced practice professional 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." ( )

b. Certified Professional Midwife (CPM). An individual who is certified by the North American Registry of Midwives (NARM) and 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." ( )

16~~7~~. **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)

17~~8~~. **Nonambulatory**. Unable to walk without assistance. (3-30-07)

18~~9~~. **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)

~~***19. Nurse Midwife (NM)**. A licensed professional nurse (RN) who meets all the applicable requirements to practice as nurse midwife under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing."* (3-30-07)~~

20. **Nurse Practitioner (NP)**. A 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." (3-30-07)

21. **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)

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

23. 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)

24. 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)

25. Oxygen-Related Equipment. Equipment which is utilized or acquired for the routine administration of oxygen in the home. 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. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

399. COVERED SERVICES UNDER BASIC PLAN BENEFITS.
Individuals who are eligible for Medicaid Basic Plan Benefits are eligible for the following benefits, subject to the coverage limitations contained in these rules. Those individuals eligible for services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," are also eligible for the services covered under this chapter of rules, unless specifically exempted. (5-8-09)

01. Hospital Services. The range of hospital services covered is described in Sections 400 through 449 of these rules. (5-8-09)

a. Inpatient Hospital Services are described in Sections 400 through 406. (3-30-07)

b. Outpatient Hospital Services are described in Sections 410 through 416. (3-30-07)

c. Reconstructive Surgery services are described in Sections 420 through 426. (3-30-07)

d. Surgical procedures for weight loss are described in Sections 430 through 436. (3-30-07)

e. Investigational procedures or treatments are described in Sections 440 through 446. (3-30-07)

02. Ambulatory Surgical Centers. Ambulatory Surgical Center services are described in Sections 450 through 499 of these rules. (5-8-09)

03. Physician Services and Abortion Procedures. Physician services and abortion procedures are described in Sections 500 through 519 of these rules. (5-8-09)

a. Physician services are described in Sections 500 through 506. (3-30-07)

b. Abortion procedures are described in Sections 510 through 516. (3-30-07)

04. Other Practitioner Services. Other practitioner services are described in Sections 520 through 559 of these rules. (5-8-09)

a. Midlevel practitioner services are described in Sections 520 through 526. (3-30-07)

b. Chiropractic services are described in Sections 530 through 536. (3-30-07)

c. Podiatrist services are described in Sections 540 through 54~~6~~5. ~~(3-30-07)~~( )

d. Certified professional midwife (CPM) services in Sections 546 through 552. ( )

~~**d**~~**e.** Optometrist services are described in Sections 55~~0~~3 through 556. ~~(3-30-07)~~( )

05. Primary Care Case Management. Primary Care Case Management services are described in Sections 560 through 569 of these rules**.** (5-8-09)

06. Prevention Services. The range of prevention services covered is described in Sections 570 through 649 of these rules. (5-8-09)

a. Health Risk Assessment services are described in Sections 570 through 576. (3-30-07)

b. Child wellness services are described in Sections 580 through 586. (3-30-07)

c. Adult physical services are described in Sections 590 through 596. (3-30-07)

d. Screening mammography services are described in Sections 600 through 606. (3-30-07)

e. Diagnostic Screening Clinic services are described in Sections 610 through 616. (3-30-07)

f. Preventive Health Assistance benefits are described in Sections 620 through 626. (5-8-09)

g. Nutritional services are described in Sections 630 through 636. (3-30-07)

h. Diabetes Education and Training services are described in Sections 640 through 646. (3-30-07)

07. Laboratory and Radiology Services. Laboratory and radiology services are described in Sections 650 through 659 of these rules. (5-8-09)

08. Prescription Drugs. Prescription drug services are described in Sections 660 through 679 of these rules. (5-8-09)

09. Family Planning. Family planning services are described in Sections 680 through 689 of these rules. (5-8-09)

10. Substance Abuse Treatment Services. Services for substance abuse treatment are described in Sections 690 through 699 of these rules. (5-8-09)

11. Mental Health Services. The range of covered Mental Health services are described in Sections 700 through 719 of these rules. (5-8-09)

a. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (3-30-07)

b. Mental Health Clinic services are described in Sections 707 through 718. (3-30-07)

12. Home Health Services. Home health services are described in Sections 720 through 729 of these rules. (5-8-09)

13. Therapy Services. Occupational therapy, physical therapy, and speech-language pathology services are described in Sections 730 through 739 of these rules. (5-8-09)

14. Audiology Services. Audiology services are described in Sections 740 through 749 of these rules.

(5-8-09)

15. Durable Medical Equipment and Supplies. The range of covered durable medical equipment and supplies is described in Sections 750 through 779 of these rules. (5-8-09)

a. Durable Medical Equipment and supplies are described in Sections 750 through 756. (3-30-07)

b. Oxygen and related equipment and supplies are described in Sections 760 through 766. (3-30-07)

c. Prosthetic and orthotic services are described in Sections 770 through 776. (3-30-07)

16. Vision Services. Vision services are described in Sections 780 through 789 of these rules. (5-8-09)

17. Dental Services. The dental services covered under the Basic Plan are covered under a selective contract as described in Section 800 through 819 of these rules. (7-1-11)T

18. Essential Providers. The range of covered essential services is described in Sections 820 through 859 of these rules. (5-8-09)

a. Rural health clinic services are described in Sections 820 through 826. (3-30-07)

b. Federally Qualified Health Center services are described in Sections 830 through 836. (3-30-07)

c. Indian Health Services Clinic services are described in Sections 840 through 846. (3-30-07)

d. School-Based services are described in Sections 850 through 856. (3-30-07)

19. Transportation. The range of covered transportation services is described in Sections 860 through 879 of these rules. (5-8-09)

a. Emergency transportation services are described in Sections 860 through 866. (3-30-07)

b. Non-emergency transportation services are described in Sections 870 through 876. (3-30-07)

20. EPSDT Services. EPSDT services are described in Sections 880 through 889 of these rules. (5-8-09)

21. Specific Pregnancy-Related Services. Specific pregnancy-related services are described in Sections 890 through 899 of these rules. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

545. ~~***553.***~~ **(RESERVED)**

546. CERTIFIED PROFESSIONAL MIDWIFE (CPM) SERVICES.
The Department will reimburse Certified Professional Midwives for maternal and newborn services performed within the scope of their practice. This section of rules does not include midlevel practitioner services provided by a nurse midwife (NM) which are described in Sections 522 through 525 of these rules. ( )

547. CPM SERVICES: DEFINITIONS.

01. NARM. The North American Registry of Midwives, the international certification agency that establishes and administers certification for the CPM credential. ( )

02. CPM. A certified professional midwife who is certified by NARM or any successor organization. ( )

03. Licensed Certified Professional Midwife. An individual who holds a current license issued by the Idaho Board of Midwifery. ( )

04. Board of Midwifery. The Idaho Board of Midwifery is located within the Idaho Bureau of Occupational Licensing and is the licensing authority for CPM providers. ( )

548. CPM SERVICES: PARTICIPANT ELIGIBILITY.
A participant is eligible for CPM services if she is pregnant, in the six (6) week postpartum period, or is a newborn up to six (6) weeks old. ( )

549. CPM SERVICES: COVERAGE AND LIMITATIONS.

01. Maternity and Newborn - Coverage. Antepartem, intrapartum, and up to six (6) weeks of postpartum maternity and newborn care are covered. ( )

02. Maternity and Newborn - Limitations. Maternal or newborn services provided after the sixth postpartum week are not covered when provided by a CPM. ( )

03. Medication - Coverage and Limitations. Licensed CPM providers may administer medication and bill Medicaid if the medication is a Medicaid covered service, and is also listed in the CPM formulary in IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." ( )

550. CPM SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Each CPM provider must: ( )

01. NARM Certified. Be certified through NARM. ( )

02. Licensed. Have a current license as a CPM from the Idaho Board of Midwifery or be licensed according to the regulations in the state where the services are provided. ( )

03. Scope of Practice. Provide only those services that are within the scope of practice under IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." ( )

551. CPM SERVICES: PROVIDER REIMBURSEMENT.
Reimbursement for CPM services will be the lesser of the billed amount, or 85% of the Department's physician fee schedule, The physician fee schedule is available from the Central Office for the Division of Medicaid as described in Section 005 of these rules, or online at: http:\\www.idmedicaid.com. ( )

552. CPM SERVICES: PROVIDER QUALITY ASSURANCE ACTIVITIES.

01. Licensure Required. Each provider must maintain licensure with the Idaho Board of Midwifery. ( )

02. Informed Consent Form Required. A signed copy of the participant's informed consent must be kept in the participant's record. ( )

03. Compliance with Board of Midwifery Requirements. The CPM must adhere to all regulations listed in IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." ( )

04. Department Access to Practice Data. All practice data submitted to the Board of Midwifery according to the provisions in IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery," must be made immediately available to the Department upon request. ( )

553. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1107

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5221(1), Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-202(b) and 56-255, Idaho Code.

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

Thursday, October 13, 2011 6:00 p.m. (Local)	Monday, October 17, 2011 6:00 p.m. (Local)	Wednesday, October 19, 2011 6:00 p.m. (Local)
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**	**Health & Welfare Region VII** **150 Shoup Ave** **2nd Floor Conf. Rm.** **Idaho Falls, ID**

The hearing sites 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 Section 56-255(5)(a)(xi) and (xii), Idaho Code, the Department is directed to limit benefits to eligible participants of the medical assistance program for physical therapy, speech therapy, and occupational therapy services. These services are to be aligned to meet the annual Medicare caps for the same services. These proposed rule changes limiting therapy services will be implemented on January 1, 2012.

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:

The anticipated fiscal impact will result in cost savings of $150,000 in state general funds for the SFY 2012, and $300,000 for each subsequent year.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is in response to 2011 legislation under HB 260.

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 Jeanne Siroky (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 26, 2011.

DATED this 8th day of September, 2011.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720
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phone: (208) 334-5564; fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0309-1107

732. THERAPY SERVICES: COVERAGE AND LIMITATIONS.
Therapy services are covered under these rules when provided by the following providers: outpatient hospitals, outpatient rehabilitation facilities, comprehensive outpatient rehabilitative facilities, nursing facilities, developmental disability agencies, school-based services, independent practitioners, and home health agencies. (4-2-08)

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 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. Therapy assistants act at the direction and under the supervision of the treating therapist and in accordance with state licensure rules. (4-2-08)

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 assistants are considered unskilled services, and will be denied as not medically necessary if they are billed as speech-language pathology services. (4-2-08)

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. (4-2-08)

b. Services that address developmentally acceptable error patterns. (4-2-08)

c. Services that do not require the skills of a therapist or therapy assistant. (4-2-08)

d. Services provided by unlicensed aides or technicians, even if under the supervision of a therapist, except as provided under Section 854 of these rules. (4-2-08)

e. Massage, work hardening, and conditioning. (4-2-08)

f. Services that are not medically necessary, as defined in Section 011 of these rules. (4-2-08)

g. Maintenance programs, as defined under Section 730 of these rules. (4-2-08)

h. Duplicate services, as defined under Section 730 of these rules. (4-2-08)

i. Group therapy in settings other than school-based services and developmental disability agencies. (4-2-08)

04. Service Limitations. (4-2-08)

a. Physical therapy (PT) and ~~*Occupational Therapy. Each participant is limited to twenty-five (25) outpatient physical therapy visits and twenty-five (25) outpatient occupational therapy visits during any calendar year*~~ 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 ~~*prior*~~ authorize additional ~~*visits if additional physical*~~ therapy ~~*or occupational therapy*~~ services, ~~*or both,*~~ when the services are determined to be medically necessary and supporting documentation is provided to the Department. ~~*(4-2-08)*~~( )

b. ~~*Speech-Language Pathology Services. Each participant is limited to forty (40) outpatient speech-language pathology visits during any calendar year.*~~ Occupational therapy services are limited to an annual dollar amount set by the Department based on the annual Medicare caps. The Department may ~~*prior*~~ authorize additional ~~*visits if additional speech-language pathology*~~ therapy services, when the services are determined to be medically necessary and supporting documentation is provided to the Department. ~~*(4-2-08)*~~( )

c. Exceptions to ~~*visit*~~ service limitations. ~~*(4-2-08)*~~( )

i. Therapy provided by home health agencies is subject to the limitations on home health ~~*visits*~~ services contained in Section 722 of these rules. ~~*(4-2-08)*~~( )

ii. Therapy provided through school-based services is not included in the ~~*visit*~~ service limitations under Subsection 732.04 of this rule. ~~*(4-2-08)*~~( )

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. ( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1108

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(7), 56-203(9), 56-250 through 56-257, 56-260 through 56-266, 56-1504, 56-1505, and 56-1511, and 56-1601 through 56-1610, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 19, 2011.

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 Department is clarifying the rules related to Medicaid's reimbursement policies to providers for non-Medicare coordination of benefits when a third party payor (insurance company) reimburses a provider for services, or when the Department determines that a third party liability exists. These policies are determined under the guidance in the Centers for Medicare & Medicaid Services State Medicaid Manual (SSM), Section 3904.7.

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: N/A

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being for clarification of current policies.

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 Robert Kellerman at (208) 364-1994.

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 31st day of August, 2011.

Tamara Prisock
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THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0309-1108

215. THIRD PARTY LIABILITY.

01. Determining Liability of Third Parties. The Department will take reasonable measures to determine any legal liability of third parties for medical care and services rendered to a participant. (3-30-07)

02. Third Party Liability as a Current Resource. The Department is to treat any third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time. (3-30-07)

03. Withholding Payment. The Department must not withhold payment on behalf of a participant because of the liability of a third party when such liability, or the amount thereof, cannot be currently established or is not currently available to pay the participant's medical expense. (3-30-07)

04. Seeking Third Party Reimbursement. The Department will seek reimbursement from a third party when the party's liability is established after reimbursement to the provider is made, and in any other case in which the liability of a third party existed, but was not treated as a current resource, with the exceptions of EPSDT and EPSDT-related services. (3-30-07)

a. The Department will seek reimbursement from a participant when a participant's liability is established after reimbursement to the provider is made; and (3-30-07)

b. In any other situation in which the participant has received direct payment from any third party resource and has not forwarded the money to the Department for services or items received. (3-30-07)

05. Billing Third Parties First. Medicaid providers must bill all other sources of direct third party payment, with the exception of absent parent (court ordered) without secondary resources, prenatal, EPSDT and EPSDT-related services before submitting the claim to the Department. If the resource is an absent parent (court ordered) and there are no other viable resources available or if the claims are for prenatal, EPSDT, or EPSDT-related services, the claims will be paid and the resources billed by the Department. (3-30-07)

06. Accident Determination. When the participant's Medicaid card indicates private insurance and/or when the diagnosis indicates an accident for which private insurance is often carried, the claim will be suspended or denied until it can be determined that there is no other source of payment. (3-30-07)

07. Third Party Payments ~~***in Excess of Medicaid Limits***~~. ~~*The Department will not reimburse providers for services provided when the amount received by the provider from the third party payor is equal to or exceeds the level of reimbursement allowed by medical assistance for the services.*~~ The Department will pay the provider the lowest amount of the following: ~~*(3-30-07)*~~( )

a. The provider's actual charge for the service; or ( )

b. The maximum allowable charge for the service as established by the Department in its pricing file. If the service or item does not have a specific price on file, the provider must submit supporting documentation to the Department. Reimbursement will be based on the documentation; or ( )

c. The third party-allowed amount minus the third party payment, or the patient liability as indicated by the third party. ( )

08. Subrogation of Third Party Liability. In all cases where the Department will be required to pay medical expenses for a participant and that participant is entitled to recover any or all such medical expenses from any third party, the Department will be subrogated to the rights of the participant to the extent of the amount of medical assistance benefits paid by the Department as the result of the occurrence giving rise to the claim against the third party. (3-30-07)

a. If litigation or a settlement in such a claim is pursued by the medical assistance participant, the participant must notify the Department. (3-30-07)

b. If the participant recovers funds, either by settlement or judgment, from such a third party, the participant must repay the amount of benefits paid by the Department on his behalf. (3-30-07)

09. Subrogation of Legal Fees. (3-30-07)

a. If a medical assistance participant incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the Department is subrogated, the amount which the Department is entitled to recover, or any lesser amount which the Department may agree to accept in compromise of its claim, will be reduced by an amount which bears the same relation to the total amount of attorney fees and court costs actually paid by the participant as the amount actually recovered by the Department, exclusive of the reduction for attorney fees and court costs, bears to the total amount paid by the third party to the participant. (3-30-07)

b. If a settlement or judgment is received by the participant which does not specify portion of the settlement or judgment which is for payment of medical expenses, it will be presumed that the settlement or judgment applies first to the medical expenses incurred by the participant in an amount equal to the expenditure for benefits paid by the Department as a result of the payment or payments to the participant. (3-30-07)

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.

Tamara Prisock
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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)