

Dear Senators MARTIN, Souza, Jordan, and
Representatives WOOD, Wagoner, Chew:

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

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Proposed Rule (Docket No. 16-0309-2002);

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Proposed Rule (Docket No. 16-0309-2004).

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 12/03/2020. 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 12/31/2020.

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 334-4854, or send a written request to the address on the
memorandum attached below.



Eric Milstead
Director

Legislative Services Office

Idaho State Legislature

Serving Idaho's Citizen Legislature

MEMORANDUM

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

FROM: Principal Legislative Drafting Attorney - Elizabeth Bowen

DATE: November 16, 2020

SUBJECT: Department of Health and Welfare

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Proposed Rule (Docket No. 16-0309-2002)

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Proposed Rule (Docket No. 16-0309-2004)

Summary and Stated Reasons for the Rule

Docket No. 16-0309-2002: This proposed rule updates existing rules to remove references to a Medicaid exclusion for services provided in institutions for mental disease (IMD). A waiver now permits reimbursements for services in an IMD setting.

Docket No. 16-0309-2004: This proposed rule waives criminal background check clearance requirements for Medicaid providers of peer support and recovering coaching, because these providers, who have a history of substance use disorder, often have drug convictions in their records. The rule also makes several changes to existing rules regarding the implementation of electronic visit verification (EVV), which will verify that Medicaid services provided in a home setting are received.

Negotiated Rulemaking / Fiscal Impact

Docket No. 16-0309-2002: Negotiated rulemaking was not conducted because it was deemed not feasible. There is no anticipated negative fiscal impact on the state general fund.

Docket No. 16-0309-2004: Negotiated rulemaking was not conducted because it was deemed not feasible. The fiscal impact on the state general fund is anticipated to be \$545,700, which was approved in SB 1418 (2020).

Statutory Authority

Docket No. 16-0309-2002: This rulemaking appears to be within the Department's statutory authority.

Docket No. 16-0309-2004: This rulemaking appears to be within the Department's statutory authority.

cc: Department of Health and Welfare
Frank Powell and Trinette Middlebrook

Kristin Ford, Manager
Research & Legislation

Paul Headlee, Manager
Budget & Policy Analysis

April Renfro, Manager
Legislative Audits

Glenn Harris, Manager
Information Technology

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***** PLEASE NOTE *****

Per the Idaho Constitution, all administrative rules may be reviewed by the Legislature during the next legislative session. The Legislature has 3 options with this rulemaking docket: **1)** Approve the docket in its entirety; **2)** Reject the docket in its entirety; or **3)** Reject the docket in part.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-2002

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 Section 56-202(b) Idaho Code and Senate Bill 1204 (2019).

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

PUBLIC HEARING
Tuesday, October 20, 2020 3:00 p.m. - 5:00 p.m. MDT
TELECONFERENCE INFORMATION Call in: 1-877-820-7831 Guest Code: 301388

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:

This chapter made reference to the federal Institutions for Mental Disease (IMD) exclusion, which no longer applies as of the effective date of the approved Medicaid waiver or state plan authority. This rulemaking removes all mentions of this exclusion in rule to allow Medicaid reimbursement for services delivered to eligible adults in an IMD setting. This confers a benefit to citizens needing treatment for substance use disorders and/or mental health disorders in an IMD setting.

The rule changes themselves have been in effect as Temporary rules since January 1, 2020, under the original Temporary Docket No. 16-0309-2001 and repromulgated as a Temporary rule under this docket number effective March 20, 2020 (see [Idaho Administrative Bulletin, April 1, 2020, Vol. 20-4, p. 40](#)).

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: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year as a result of this rulemaking:

Senate Bill 1204 (2019) shifted budget dollars from the Division of Behavioral Health to the Division of Medicaid to pay for costs of Medicaid Expansion, including the costs of the sideboards and waivers. Therefore, this rule change will have no net impacts to the State General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because it was not feasible. This rulemaking is being done to align with S1204 (2019).

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the proposed rule, contact Clay Lord at (208) 364-1979.

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 28, 2020.

Dated this 14th day of August, 2020.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5564
Fax: (208) 334-6558
dhwrules@dhw.idaho.gov

Pursuant to Section 67-5221(1), Idaho Code, this docket is being published as a proposed rule.

**This docket has been previously published as a temporary rule.
The temporary effective date is March 20, 2020.**

**The original text of the temporary rule was published in the Idaho Administrative Bulletin,
Volume 20-4, April 1, 2020, pages 40 through 43.**

**THE FOLLOWING IS THE PROPOSED TEXT FOR DOCKET NO. 16-0309-2002
(Only Those Sections With Amendments Are Shown.)**

701. INPATIENT BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.

01. Inpatient Psychiatric Hospital Services. Participants are eligible who have a diagnosis from the current DSM with substantial impairment in thought, mood, perception, or behavior. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for these services. Medical necessity must be demonstrated for admission or extended stay by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. Services may be provided in: (7-1-18)

a. A freestanding psychiatric hospital; (7-1-18)

b. A hospital psychiatric unit; and (7-1-18)()

c. Subject to federal approval, an institutions for mental diseases. for participants meeting the conditions in Subsections 701.01.e.i. and 701.01.e.ii. of this rule. (7-1-18)()

i. Participants must be under the age of twenty one (21); and (7-1-18)

ii. If a participant reaches age twenty one (21) while receiving services, he may continue inpatient treatment until services are no longer required, or he reaches age twenty two (22), whichever comes first. (7-1-18)

02. Inpatient Substance Use Disorder Services. Participants are eligible when medical necessity is demonstrated by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid

reimbursement for these services. ~~Services may be provided in:~~ (7-1-18)()

~~a. A freestanding psychiatric hospital;~~ or (7-1-18)

~~b. A hospital psychiatric unit.~~ (7-1-18)

03. Severity of Illness Criteria. Both severity of illness and intensity of services criteria must be met for admission to an IMD or psychiatric unit of a general hospital. (7-1-18)

a. Severity of illness criteria. The participant must meet one (1) of the following criteria related to the severity of ~~his~~ their psychiatric illness: (7-1-18)()

i. Is currently dangerous to self as indicated by at least one (1) of the following: (3-30-07)

(1) Has actually made an attempt to take ~~his~~ their own life in the last seventy-two (72) hours (details of the attempt must be documented); or (3-30-07)()

(2) Has demonstrated self-mutilative behavior within the past seventy-two (72) hours (details of the behavior must be documented); or (3-30-07)

(3) Has a clear plan to seriously harm himself, overt suicidal intent, and lethal means available to follow the plan (this information can be from the participant or a reliable source and details of the participant's plan must be documented); or (7-1-18)

(4) The participant has a current plan, specific intent, or recurrent thoughts to seriously harm himself or others, and is at significant risk of making an attempt without immediate intervention; or (7-1-18)

ii. Participant is actively violent or aggressive and exhibits homicidal ideation or other symptoms ~~which that~~ indicate ~~they is~~ are a probable danger to others as indicated by one (1) of the following: (7-1-18)()

(1) The participant has engaged in, or threatened, behavior harmful or potentially harmful to others or caused serious damage to property ~~which that~~ would pose a serious threat of injury or harm to others within the last twenty-four (24) hours (description of the behavior and extent of injury or damage must be documented, as well as the time the behavior occurred relative to the present); or (7-1-18)()

(2) The participant has made threats to kill or seriously injure others or to cause serious damage to property ~~which that~~ would pose a threat of injury or harm to others and has effective means to carry out the threats (details of threats must be documented); or (7-1-18)()

(3) A mental health professional has information from the participant or a reliable source that the participant has a current plan, specific intent, or recurrent thoughts to seriously harm others or property and is at significant risk of making the attempt without immediate intervention (details must be documented); or (7-1-18)

iii. Participant is gravely impaired as indicated by at least one (1) of the following criteria: (7-1-18)

(1) The participant has such limited functioning that ~~his~~ their physical safety and well being are in jeopardy due to ~~his~~ their inability for basic self-care, judgment, and decision making (details of the functional limitations must be documented); or (7-1-18)()

(2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the participant unmanageable and unable to cooperate in non-hospital treatment (details of the participant's behaviors must be documented); or (7-1-18)

(3) There is a need for treatment, evaluation, or complex diagnostic testing where the participant's level of functioning or communication precludes assessment ~~and~~ or treatment, or both, in a non-hospital based setting, and may require close supervision of medication or behavior or both. (7-1-18)()

(4) The participant is undergoing severe or medically complicated withdrawal from alcohol, opioids, stimulants, or sedatives. (7-1-18)

04. Intensity of Service Criteria. The participant must meet all of the following criteria related to the intensity of services needed for treatment. (7-1-18)

a. Documentation that ambulatory care resources available in the community do not meet the treatment needs of the participant; and (7-1-18)

b. The services provided can reasonably be expected to improve the participant's condition or prevent further regression so that inpatient services will no longer be needed; and (7-1-18)

c. Treatment of the participant's condition requires services on an inpatient basis, including twenty-four (24) hour nursing observation. (7-1-18)

d. Exceptions. The requirement to meet intensity of service criteria may be waived for first-time admissions if severity of illness is met and the physician is unable to make a diagnosis or treatment decision while the participant is in ~~his~~ **their** current living situation. The waiver of the intensity of services requirement can be for no longer than forty-eight (48) hours and is not waivable for repeat hospitalizations. (7-1-18)()

05. Exclusions. If a participant meets one (1) or more of the following criteria, Medicaid reimbursement will be denied: (7-1-18)

a. The participant is unable to actively participate in an outpatient treatment program solely because of a major medical condition, surgical illness or injury; or (7-1-18)

b. The participant has a primary diagnosis of being intellectually disabled and the primary treatment need is related to the intellectual disability. (7-1-18)

702. INPATIENT BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. Initial Length of Stay. An initial length of stay, or a prior authorization requirement, will be established by the Department, or its designee, in the Idaho Medicaid Provider Handbook. Requirements for establishing length of stay will never be more restrictive than requirements for non-behavioral health services in a general hospital. (7-1-18)

02. Extended Stay. The Department, or its designee, will establish authorization requirements in the Idaho Medicaid Provider Handbook. An authorization is necessary when the appropriate care of the participant indicates the need for inpatient days in excess of the initial length of stay or previously approved extended stay. (7-1-18)

~~**03. Excluded Services.** Placement in an IMD for participants between the ages of twenty-one (21) and sixty-four (64) is not a covered service. (7-1-18)~~

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-2004

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 Section 56-202(b) and the 21st Century Cures Act – Public Law 114–255, Section 12006.

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

PUBLIC HEARINGS

**For Electronic Visit Verification (EVV) --
Wednesday, October 14, 2020, 3:00 p.m. - 5:00 p.m. MDT**

WebEx INFORMATION

WebEx Phone:

+1-415-655-0003 US Toll

+1-720-650-7664 United States Toll

Meeting Number (Access Code): 133 127 0087

Meeting password: medicaidhearing (63342243 from phones and video systems)

WebEx Link:

<https://idhw.webex.com/idhw/j.php?MTID=m552a7147cb81abe347c3ac20a559c64c>

**For Waiver of Criminal History Check for Peer Support/Recovery Coaching --
Tuesday, October 20, 2020, 3:00 p.m. - 5:00 p.m. MDT**

TELECONFERENCE INFORMATION

Call in: 1-877-820-7831

Guest Code: 301388

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:

1. Peer Support and Recovering Coaching: There is an ongoing issue with the availability of Peer Support and Recovery Coaching services delivered through the Idaho Behavioral Health Plan (IBHP). Qualified providers of these services have lived experience with substance use disorders; however, prospective providers who are recovering addicts frequently have drug convictions on their criminal records, and therefore cannot obtain criminal history check clearance. This change would allow the Department to waive clearance requirements for these providers, which in turn would expand access to these services.

2. Electronic Visit Verification (EVV): These rule changes secure State authority to implementation of an Electronic Visit Verification (EVV) system to comply with the 21st Century Cures Act while helping minimize provider administrative burden. EVV Implementation aims to protect participants by verifying services are received using an electronic verification method, and also aims to reduce instances of fraud, waste, and abuse by providers who bill for these services. Medicaid is in the process of implementing an Open Model structure for providers, allowing providers freedom to choose the EVV provider that best fits with each agency's budget and needs as long as it is certified as compatible with the Data Aggregator DXC Technology (Medicaid's existing Medicaid Management Information System vendor) will launch to process EVV claims. DXC will also include provider training and

certification to help the implementation process. Rulemaking will be as minimal as possible, to ensure CMS compliance with the Act, while procedural guidance will be provided via Idaho Provider Handbook and DXC training materials.

The Department also intends to take this opportunity to simplify existing procedural requirements in rule related to Home Health services that correspond to EVV implementation.

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: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year as a result of this rulemaking:

For Peer support and recovery coaching: there are no fiscal impacts to the State General Fund expected if the changes are implemented, since the services are currently available to any Medicaid participant who needs them. By increasing the size of the provider pool, the change is intended to decrease the number of days Medicaid participants must wait to book appointments with providers. Decreasing delays in the onset of treatment is critical to the success of Idaho's response to the opioid crisis.

For EVV: Senate Bill 1418 (2020) approved EVV implementation costs that include a one-time system expense of \$545,700 from the SGF for SFY 2020. This cost is the combined shared sum with the EVV implementation for Docket No. 16-0310-2002 implementing EVV for Personal Care Services (PCS) and Aged and Disabled (A&D) waiver services. In order to minimize financial impact to SGF, the Department chose to do the minimum system implementation by amending the contract with our current MMIS contractor (DXC Technologies) to add an MMIS Aggregator for EVV and provide training and validation for providers that must comply with EVV requirements. Providers are allowed the choice of the EVV Solution that meets their agency's budget and process needs, as long as it is verified as compatible by the MMIS subcontractor in charge of the EVV work. Ongoing support and maintenance related to EVV systems will include a monthly fee, but this is incorporated in the annually approved MMIS Contract and not expected to add to an additional line item for future budget years. In the Department budget approved during the 2020 Legislative Session, the total breakdown for EVV service implementation (under this docket and Docket No. 16-0310-2002) is as follows: State General Fund Allocation: \$545,700, Federal Fund Allocation: \$1,828,700, and Total Allocation: \$2,374,400.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because negotiated rulemaking was not feasible. However, extensive informal negotiated rulemaking was conducted with stakeholders in 2019 and 2020.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the proposed rule, contact Jennifer Pinkerton (208) 287-1171.

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 28, 2020.

Dated this 14th day of August, 2020.

Tamara Priscock, DHW – Administrative Rules Unit
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P.O. Box 83720
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Fax: (208) 334-6558
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THE FOLLOWING IS THE PROPOSED TEXT FOR DOCKET NO. 16-0309-2004
(Only Those Sections With Amendments Are Shown.)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. **Compliance With Department Criminal History Check.** Criminal history checks are required for certain types of providers under these rules. Providers who are required to have a criminal history check must comply with IDAPA 16.05.06, "Criminal History and Background Checks." (3-30-07)

02. Department-Issued Variances to Requirements for a Criminal History Check Clearance. ()

a. Notwithstanding those provider types required to obtain a criminal history check clearance or Department enhanced clearance under these rules or under IDAPA 16.05.06, "Criminal History and Background Checks," the Department at its discretion may allow variances to clearance requirements under certain circumstances. Providers who are subject to a criminal history and background check must still complete and notarize an application for a criminal history and background check. ()

b. In cases where the application process results in a denial rather than a clearance, and the denial is due to the applicant's prior convictions for disqualifying drug and alcohol offenses, the applicant may, with prior written approval of the Department, deliver covered Medicaid Peer Support and Recovery Coaching services. ()

c. A variance may be granted on a case-by-case basis upon review by the Department or its designee of any underlying facts and circumstances in each individual case. The Department will establish the process for the administrative review which will be conducted separate from the criminal history unit. During the Department's review, the following factors may be considered: ()

i. The severity or nature of the crimes or other findings; ()

ii. The period of time since the incidents occurred; ()

iii. The number and pattern of incidents being reviewed; ()

iv. Circumstances surrounding the incidents that would help determine the risk of repetition; ()

v. The relationship between the incidents and the position sought; ()

vi. Activities since the incidents, such as continuous employment, education, participation in treatment, completion of a problem-solving court or other formal offender rehabilitation, payment of restitution, or any other factors that may be evidence of rehabilitation; ()

vii. A pardon that was granted by the Governor or the President of the United States; ()

viii. The falsification or omission of information on the self-declaration form and other supplemental forms submitted; and ()

ix. Any other factor deemed relevant to the review. ()

d. A variance granted under these rules is not a criminal history and background check clearance and does not set a precedent for subsequent application for variance. The Department may revoke a variance when it identifies a risk to participants' health and safety. Providers who have been granted a variance must still meet all other Department requirements for Medicaid coverage and reimbursement of Peer Support and Recovery Coaching services, and are prohibited from delivering any other covered Medicaid service without the required clearance or

Department enhanced clearance.

()

023. Availability to Work or Provide Service. (3-30-07)

a. The employer, at its discretion, may allow an individual to provide care or services on a provisional basis once the application for a criminal history and background check is completed and notarized, and the employer has reviewed the application for any disqualifying crimes or relevant records. The employer determines whether the individual could pose a health and safety risk to the vulnerable participants it serves. The individual is not allowed to provide care or services when the employer determines the individual has disclosed a disqualifying crime or relevant records. (3-30-07)

b. Those individuals licensed or certified by the Department are not available to provide services or receive licensure or certification until the criminal history and background check is completed and a clearance issued by the Department. (3-30-07)

034. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (3-30-07)

045. Providers Subject to Criminal History Check Requirements. The following providers must receive a criminal history clearance: (3-30-07)

a. Contracted Non-Emergency Medical Transportation Providers. All staff of transportation providers having contact with participants must comply with IDAPA 16.05.06, "Criminal History and Background Checks," with the exception of individual contracted transportation providers defined in Subsection 870.02 of these rules. (4-7-11)

b. Provider types deemed by the Department to be at high risk for fraud, waste, and abuse under Subsection 200.02 of these rules must consent to comply with criminal background checks, including fingerprinting, in accordance with 42 CFR 455.434. (3-20-14)

(BREAK IN CONTINUITY OF SECTIONS)

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 a complete and properly submitted claim for payment has been received and each of the following conditions are met: (3-20-14)

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. (3-20-14)

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.d. of this rule does not apply with respect to retroactive eligibility adjustment. 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. (3-20-14)

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. (3-20-14)

07. Referral From Participant's Assigned Primary Care Provider. Medicaid services may require a referral from the participant's assigned primary care provider. Services requiring a referral are listed in the Idaho Medicaid Provider Handbook. Services provided without a referral, when one is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require a referral after appropriate notification of Medicaid-eligible individuals and providers as specified in Section 563 of these rules. (3-25-16)

08. Follow-up Communication with Assigned Primary Care Provider. Medicaid services may require timely follow-up communication with the participant's assigned primary care provider. Services requiring post-service communication with the primary care provider and time frames for that communication are listed in the Idaho Medicaid Provider Handbook. Services provided without timely communication of care outcomes, when communication is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require communication of care outcomes after appropriate notification of Medicaid eligible individuals and providers as specified in Section 563 of these rules. (3-25-16)

09. Services Delivered Via Telehealth. Services delivered via telehealth as defined in Title 54, Chapter 57, Idaho Code, must be identified as such in accordance with billing requirements published in the Idaho Medicaid Provider Handbook. Telehealth services billed without being identified as such are not covered. Services delivered via telehealth may be reimbursed within limitations defined by the Department in the Idaho Medicaid Provider Handbook. Fee for service reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a physician and a participant. (3-25-16)

10. Services Subject to Electronic Visit Verification (EVV). Services requiring EVV compliance are subject to quality review. EVV services billed without the minimum essential elements, as defined by Section 1903(1)(2) of the Social Security Act, may be denied, delayed, or subject to sanctions or recoupment, or both, in accordance with IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." ()

(BREAK IN CONTINUITY OF SECTIONS)

720. HOME HEALTH SERVICES: DEFINITIONS.

01. Aggregator. System that collects provider EVV information from multiple software platforms and standardizes the information in MMIS for EVV data validation. ()

02. Claims Adjudication. The process of determining Medicaid financial responsibility for claims

submitted to MMIS. ()

03. Electronic Visit Verification (EVV). EVV is a software or device(s) that electronically captures information verifying services delivered in a participant's home. ()

014. Home Health Plan of Care. A written description of home health services to be provided to a participant as defined in IDAPA 16.03.07, "Home Health Agencies." (7-1-17)()

025. Home Health Services. Home health services ~~are services~~ and items, including ~~ing~~ nursing services, home health aide services, physical therapy, occupational therapy, speech-language pathology services, audiology services, and medical supplies, equipment, and appliances ~~that are:~~ provided under a home health plan of care. (7-1-17)()

~~a. Ordered by a physician as part of a home health plan of care; (7-1-17)~~

~~b. Performed by a licensed, qualified professional acting within their authorized scope of practice; (7-1-17)~~

~~c. Typically received by a participant at the participant's place of residence, but may be received in any setting in which normal life activities take place, other than a hospital, nursing facility, ICF/ID (unless such services are not otherwise required to be provided by the ICF/ID), or any other setting in which payment is made, or could be made, under Medicaid for inpatient services that include room and board; and (7-1-17)~~

~~d. Reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. (7-1-17)~~

~~03. Place of Residence.~~ For the purposes of home health services, generally any setting in which a participant makes their home, other than a hospital, nursing facility, or ICF/ID. (7-1-17)

721. (RESERVED)

722. HOME HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. Settings. Home health services are covered in a participant's place of residence and any setting in which normal life activities take place. Services are not covered when provided in a: ()

~~a. Hospital; ()~~

~~b. Nursing facility; ()~~

~~c. ICF/IID, unless such services are not otherwise required to be provided by the ICF/IID; or ()~~

~~d. Any setting in which Medicaid covers inpatient services, including room and board. ()~~

02. Limitations. Home health ~~visits~~ services are limited to one hundred (100) visits per calendar year per person. (3-30-07)()

03. Requirements. Services and items must be medically necessary and when appropriate, meet the requirements for: ()

~~a. Audiology services under Sections 740 through 749 of these rules; ()~~

~~b. Medical supplies, items, and appliances under Sections 750 through 779 of these rules; ()~~

~~c. Physical therapy, occupational therapy, and speech-language pathology services under Sections 730 through 739 of these rules; and ()~~

d. Early Periodic, Screening, Diagnosis, and Treatment Services under Sections 880 through 889 of these rules. ()

723. HOME HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

01. ~~Physician~~ Orders. (7-1-17)()

a. Home health services must be ordered by a physician, nurse midwife, nurse practitioner, clinical nurse specialist, or physician assistant. ~~Such o~~Orders must include at a minimum, the ~~physician's provider's~~ National Provider Identifier (NPI), the services or items to be provided, the frequency, and, where applicable, the expected duration of time for which the home health services will be needed. Orders for medical supplies, equipment, and appliances are detailed in Section 753 of these rules. (7-1-17)()

b. ~~In the event that h~~Home health services ~~are~~ required for extended periods, ~~these services~~ must be reordered ~~as necessary, but~~ at least every sixty (60) days for services and ~~at least~~ annually for medical supplies, equipment, and appliances. (7-1-17)()

02. Face-to-Face Encounter for Home Health Services, ~~—Excluding—~~Medical Supplies, Equipment, and Appliances. (7-1-17)()

a. ~~For the initiation of~~ To initiate home health services, ~~excluding~~ medical supplies, equipment, and appliances, the participant's physician, or a non-physician practitioner as authorized in this rule, must document ~~that~~ a face-to-face encounter ~~that is~~ related to the primary reason the patient requires home health services, ~~occurred with the participant no more than ninety (90) days before, or thirty (30) days after, the start of the home health services.~~ ~~Appropriate d~~Documentation must indicate the practitioner who conducted the encounter, and the date of the encounter as described in the CMS/Medicare DME coverage manual. (7-1-17)()

i. For home health services, the face-to-face encounter must have occurred no more than ninety (90) days before, or thirty (30) days after, the start of the home health services. ()

ii. For home health medical supplies, equipment, and appliances, the face-to-face encounter must have occurred no more than six (6) months before the start of services. ()

b. The face-to-face encounter may occur via telehealth, as defined in ~~Title 54, Chapter 57, Idaho Code~~ Subsection 210.09 of these rules. (7-1-17)()

c. The face-to-face encounter may be performed by ~~participant's physician, including an attending acute or post-acute physician, or one (1) of the following non-physician practitioners (NPP):~~ (7-1-17)()

i. The participant's physician, including an attending acute or post-acute physician; ()

ii. A nurse practitioner or clinical nurse specialist ~~working in collaboration with the ordering physician;~~ (7-1-17)()

iii. A nurse midwife; or (7-1-17)

iiiv. A physician assistant ~~under the supervision of the ordering physician.~~ (7-1-17)()

~~d. If the face-to-face encounter is performed by an allowed NPP, the NPP must communicate the clinical findings of that face to face encounter to the ordering physician.~~ (7-1-17)

~~03. Face-to-Face Encounter for Home Health Medical Supplies, Equipment, and Appliances.~~ (7-1-17)

~~a. For the initiation of home health medical supplies, equipment, and appliances, the participant's physician, or a non-physician practitioner as authorized in Subsection 723.03 of this rule, must document that a face-to-face encounter that is related to the primary reason the patient requires medical supplies, equipment, and~~

~~appliances, occurred with the participant no more than six (6) months before the start of services. Appropriate documentation must indicate the practitioner who conducted the encounter, and the date of the encounter as described in the CMS/Medicare DME coverage manual. (7-1-17)~~

~~**b.** The face to face encounter may occur via telehealth, as defined in Title 54, Chapter 57, Idaho Code. (7-1-17)~~

~~**e.** The face to face encounter may be performed by participant's physician, including an attending acute or post-acute physician, or one (1) of the following non-physician practitioners (NPP): (7-1-17)~~

~~**i.** A nurse practitioner or clinical nurse specialist working in collaboration with the ordering physician; or (7-1-17)~~

~~**ii.** A physician assistant under the supervision of the ordering physician. (7-1-17)~~

~~**d.** If the face-to-face encounter is performed by an allowed NPP, the NPP must communicate the clinical findings of that face to face encounter to the ordering physician. (7-1-17)~~

043. Home Health Plan of Care. (7-1-17)

a. All home health services must be provided under a home health plan of care that is established prior to beginning treatment. ~~The home health plan of care and~~ must be signed by the licensed, qualified professional who established the plan ~~and must contain the information required under IDAPA 16.03.07, "Home Health Agencies."~~ (7-1-17)()

b. All home health plans of care must be reviewed by the ~~participant's physician as necessary, but~~ ordering provider at least every sixty (60) days for services, and ~~at least~~ annually for medical supplies, equipment, and appliances. (7-1-17)()

724. ELECTRONIC VISIT VERIFICATION (EVV).

Effective July 1, 2021, Home Health Agencies (HHA) are required to submit claims using a compliant EVV system as mandated by Section 12006 of the 21st Century Cures Act for all services provided in the participant's residence, except for the provision of medical supplies and equipment. Providers must: ()

01. Maintain System. Maintain an EVV system chosen by their agency that is certified as compliant with the MMIS aggregator, as determined by the Department and/or the MMIS Contractor; ()

02. Document Consent. Document and retain participant consent for use of location and identity verification methods; ()

03. Develop Policies and Procedures. Develop and maintain policies and procedures outlining agency implementation and use of EVV technology, including strategies for safeguarding of participant information and privacy; and ()

04. Submit EVV Data. Submit EVV data that captures these six (6) system-validated data elements for services delivered in the participant's home: ()

a. Date of service; ()

b. Time the service begins and ends; ()

c. Individual providing the service; ()

d. Participant receiving the service; ()

e. Type of service performed; and ()

f. Location of service delivery. ()

7245. HOME HEALTH SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

In order to participate as a Home Health Agency (HHA) provider for Medicaid-eligible persons, the provider must be licensed as required by the state, and be certified to participate in the Medicare Program. Loss of either state license or Medicare Program certification is cause for termination of Medicaid provider status. (3-30-07)

7256. HOME HEALTH SERVICES: PROVIDER REIMBURSEMENT.

~~01. Mileage Included in Cost. Payment by the Department for home health services will include mileage as part of the cost of the visit. (3-30-07)~~

~~02. Payment Procedures-Home Health Services. Payment for home health services will be is limited to the services authorized in Sections 720 through 722 of these rules and must not exceed the lesser of reasonable cost as determined by Medicare or the Medicaid percentile cap. (3-30-07)()~~

~~a. For visits performed in the first state fiscal year for which this Subsection is in effect, the Medicaid percentile cap will be established at the seventy fifth percentile of the ranked costs per visit as determined by the Department using the data from the most recent finalized Medicare cost reports on hand in the Department on June 1, 1987. Thereafter, the Medicaid percentile cap will be is revised annually, effective at the beginning of each state fiscal year. Revisions will be are made using the data from the most recent finalized Medicare cost reports on hand thirty (30) days prior to the effective date. (3-30-07)()~~

~~b. When determining reasonable costs of rented medical equipment ordered by a physician and used for the care of the participant, the total rental cost of a Durable Medical Equipment (DME) item must not exceed one-tenth (1/10) of the total purchase price of the item. A minimum rental rate of fifteen dollars (\$15) per month is allowed on all DME items. Payment by the Department for home health will include mileage as part of the cost of the visit. (7-1-17)()~~

~~c. The Department may enter into lease/purchase agreements with providers in order to purchase medical equipment when the rental charges total the purchase price of the equipment. Provider claims for services requiring EVV will include the corresponding EVV data elements listed in Subsection 724.04 of these rules. Provider EVV data will be submitted to the state's aggregator prior to billing claims. Claims corresponding to EVV data submissions are subject to a quality review in accordance with Subsection 210.09 of these rules. (3-30-07)()~~

~~d. The Department will not pay for services at a cost in excess of prevailing Medicare rates. (3-30-07)~~

~~e. If a person is eligible for Medicare, all services ordered by the physician will be purchased by Medicare, except for the deductible and co-insurance amounts that the Department will pay. (3-30-07)~~

~~02. Medical Supplies, Equipment, and Appliances. Payment for medical supplies, equipment, and appliances is detailed in Section 755 of these rules. ()~~

7267. -- 729. (RESERVED)