

Meeting Agenda

May 15, 2012 1:00 p.m. – 3:00 p.m. (MST)

Type of Meeting: Negotiated Rulemaking Docket No. 16-0310-1201

Meeting Facilitator: Lisa Hettinger

Invitees: Open to the General Public

I. Call to order

II. Roll call-Phone in

III. Purpose of Meeting

a) Consider quality and incorporate requirements of 42 U.S.C. 1396a(30)(A) for future reimbursement changes.

b) The goal of the above CFR is to prevent unnecessary use of care and services, and ensure that payments are sufficient to enlist enough providers to meet the need for care and services in a given geographic area.

IV. Discussion Points

- a) Access to services
- b) Payments consistent with efficiency
- c) Payments consistent with quality of care
- d) Suggestions regarding cost survey methodology

V. Follow-up

a) Written comments for Docket No. 16-0310-1201 are to be submitted by 5/25/12:

Tamara Prisock 450 W. State Street – 10th Floor P.O. Box 83720 Boise, ID 83720-0036

- b) Website www.healthandwelfare.idaho.gov
- c) Click Providers Link, Under Resources Section
- d) Comments will be posted by July 2, 2012

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS DOCKET NO. 16-0310-1104

NOTICE OF RULEMAKING - FINAL RULE

EFFECTIVE DATE: The effective date of this final rule is March 21, 2012.

AUTHORITY: In compliance with Sections 67-5224 and 67-5291, Idaho Code, notice is hereby given that the legislature has taken action by concurrent resolution on this rulemaking promulgated under Docket No.16-0310-1104 and this agency is publishing a final rule pursuant to that legislative action. This agency action for this final rulemaking is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, Idaho Code; and 2011 House Bill 260.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the final rule and a statement of any change between the text of the pending rule and the text of the final rule with an explanation of the reasons for the change.

Pursuant to Senate Concurrent Resolution No. 114, IDAPA 16.03.10, Medicaid Enhanced Plan Benefits, certain rules promulgated under Docket 16-0310-1104 are not consistent with legislative intent and are rejected. The following subsections:

Section 119, Subsections 02.b and 03, Enhanced Outpatient Mental Health Services: Provider Reimbursement;

Section 140, Subsection 08.b and 09, Psychosocial Rehabilitative Services (PSR): Provider Reimbursement;

Section 659, Subsections 01.b and 02, DDA Services: Provider Reimbursement;

Section 706, Subsections 04 and 05, Adult DD Waiver Services: Provider Reimbursement;

Section 736, Subsections 09 and 10, Service Coordination: Provider Reimbursement;

Adopted as pending rules under Docket 16-0310-1104 are hereby rejected. In accordance with the concurrent resolution, the affected Sections of this final rule will be codified into the Idaho Administrative Code with the changes in this rulemaking to these subsections being rejected and declared null, void, and of no force and effect.

The original text of the proposed rule was published in the August 3, 2011, Idaho Administrative Bulletin, Vol. 11-8, pages 114 through 124. The pending rule was published in the December 7, 2011, Idaho Administrative Bulletin, Vol. 11-12, pages 66 through 70.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Robert Kellerman at (208) 364-1994.

DATED this 6th day of April, 2012.

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

> THE FOLLOWING IS THE FINAL TEXT OF DOCKET NO. 16-0310-1104 SECTIONS AFFECTED BY SCR 114, ONLY

DEPARTMENT OF HEALTH AND WELFARE
Medicaid Enhnaced Plan Benefits

Docket No. 16-0310-1104 Final Rule

119. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: PROVIDER REIMBURSEMENT.

- **01. Medical Assistance Upper Limit.** The Department's medical assistance upper limit for reimbursement is the lower of: (3-21-12)
 - a. The mental health clinic's actual charge; or

(3-21-12)

- b. The allowable charge as established by the Department's medical assistance fee schedule. Mental health clinic reimbursement is subject to the provisions of 42 CFR 447.321. (3-21-12)
- **02. Reimbursement.** For physician services where mid-levels are authorized to administer mental health services, the Department reimburses based on the Department's medical assistance fee schedule. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

- 140. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR): PROVIDER REIMBURSEMENT. Payment for PSR agency services must be in accordance with rates established by the Department. The rate paid for services includes documentation. (5-8-09)
- **01. Duplication**. Payment for services must not duplicate payment made to public or private entities under other program authorities for the same purpose. (3-19-07)
- **02.** Number of Staff Able to Bill. Only one (1) staff member may bill for an assessment, individualized treatment plan, or case review when multiple agency staff are present. (5-8-09)
- **03. Medication Prescription and Administration**. Medication prescription and administration may be billed only by physicians and other medical staff qualified under Title 54, Chapter 18, Idaho Code. (3-19-07)
- **Q4.** Recoupment. Billing for services and receiving reimbursement for services that were not rendered or failure to comply with these rules must be cause for recoupment of payments for services, sanctions, or both.

 (3-19-07)
- **05.** Access to Information. Upon request, the provider must provide the Department with access to all information required to review compliance with these rules. Failure by the provider to comply with such a request must result in termination of the Medicaid PSR Provider Agreement. (3-19-07)
- **06. Evaluations and Tests.** Evaluations and tests are a reimbursable service if provided in accordance with the requirements in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (5-8-09)
- **O7. Psychiatric or Medical Inpatient Stays.** Community reintegration services may be provided during the last thirty (30) days of inpatient stay or if the inpatient stay is not expected to last longer than thirty (30) days, when not duplicating those services included in the responsibilities of the inpatient facility. Treatment services are the responsibility of the facility. (5-8-09)

08. Reimbursement. (3-21-12)

- a. For physician services where mid-levels are authorized to administer mental health services, the Department reimburses based on the Department's medical assistance fee schedule. (3-21-12)
- **b.** Crisis assistance for adults with serious and persistent mental illness (SPMI) will be paid based on the same reimbursement methodology as service coordination crisis intervention services defined in Subsection 736.09 of these rules. (3-21-12)

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(BREAK IN CONTINUITY OF SECTIONS)

659. DDA SERVICES: PROVIDER REIMBURSEMENT.

For physician services where mid-levels are authorized to administer developmental disability services, the Department reimburses based on the Department's Medical Assistance fee schedule. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

706. ADULT DD WAIVER SERVICES: PROVIDER REIMBURSEMENT.

- **01. Fee for Service.** Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (3-19-07)
- **O2.** Claim Forms. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (3-19-07)
- 03. Rates. The reimbursement rates calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation.

 (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

736. SERVICE COORDINATION: PROVIDER REIMBURSEMENT.

- **O1. Duplication.** Participants are only eligible for one (1) type of service coordination. If they qualify for more than one (1) type, the participant must choose one (1). Service coordination payment must not duplicate payment made to public or private sector entities under other program authorities for this same purpose. (3-19-07)
- **02. Payment for Service Coordination**. Subject to the service limitations in Subsection 736.06 of this rule, only the following services are reimbursable: (5-8-09)
 - a. Service coordination plan development defined in Section 721 of these rules. (5-8-09)
 - **b.** Face-to-face contact required in Subsection 728.07 of these rules. (5-8-09)
- c. Two-way communication between the service coordinator and the participant, participant's service providers, family members, primary care givers, legal guardian, or other interested persons. (5-8-09)
- **d.** Face-to-face contact between the service coordinator and the participant's family members, legal representative, primary caregivers, providers, or other interested persons. (3-19-07)
- e. Referral and related activities associated with obtaining needed services as identified in the service coordination plan. (5-8-09)
- 03. Service Coordination During Institutionalization. Service coordination is reimbursable on the day a participant is admitted to a medical institution if the service is provided prior to admission. Service coordination is reimbursable on the day of discharge from a medical institution if the service is provided after discharge. (5-8-09)

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- a. Service coordination for reintegration into the community, can only be provided by and reimbursed to a service coordination agency when the following applies: (5-8-09)
- i. During the last fourteen (14) days of an inpatient stay which is less than one hundred eighty (180) days in duration; or (5-8-09)
 - ii. During the last sixty (60) days of an inpatient stay of one hundred eighty (180) days or more. (5-8-09)
- **b.** Service coordination providers may not file claims for reimbursement until the participant is discharged and using community services; (5-8-09)
- c. Service coordination must not duplicate activities provided as part of admission or discharge planning activities of the medical institution. (5-8-09)
 - **104. Incarceration.** Service coordination is not reimbursable when the participant is incarcerated. (3-19-07)
- **95. Services Delivered Prior to Assessment.** Payment for on-going service coordination will not be made prior to the completion of the service coordination plan. (5-8-09)
- **96. Payment Limitations.** Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid service coordinator, transporting participants, or documenting services. (5-8-09)
- a. Service coordination providers are paid in unit increments of fifteen (15) minutes each. A service coordinator can only be reimbursed for the amount of time worked and must not bill for more than four (4) billing units per hour. The following table is an example of minutes to billing units. (5-8-09)

Services Provided Are More Than Minutes	Services Provided Are Less Than Minutes	Billing Units	
. 8	23	1	
22	38	2	
37	53	3	
52	68	4	
67	83	5	
82	98	6	
97	113	7	

(5-8-09)

- **b.** Direct delivery of medical, educational, psychiatric, social, early intervention, or other service to which a participant has been referred is not reimbursable as service coordination. (5-8-09)
- **c.** Activities that are an integral component of another covered Medicaid service are not reimbursable as service coordination. (5-8-09)
- **d.** Activities that are integral to the administration of foster care programs are not reimbursable as service coordination. (5-8-09)
- e. Activities that are integral to the administration of another non-medical program are not reimbursable as service coordination. This exclusion does not apply to case management provided as part of the

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individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. (5-8-09)

- **07. Healthy Connections.** A participant enrolled in Healthy Connection must receive a referral for assessment and provision of services from his Healthy Connections provider. To be reimbursed for service coordination, the Healthy Connections referral must cover the dates of service delivery. (3-21-12)
- **08. Group Service Coordination.** Payment is not allowed for service coordination provided to a group of participants. (3-19-07)

- e. Assignment of qualified personal assistants to eligible participants after consultation with and approval by the participants; (3-19-07)
 - f. Assuring that all personal assistants meet the qualifications in Subsection 305.01 of these rules; (3-19-07)
 - g. Billing Medicaid for services approved and authorized by the RMS; (3-19-07)
 - h. Collecting any participant contribution due; (5-8-09)
- i. Conducting, at least annually, participant satisfaction or quality control reviews which are available to the Department and the general public; and (5-8-09)

307. PERSONAL CARE SERVICES: PROVIDER REIMBURSEMENT.

- 01. Reimbursement Rate. Personal assistance providers will be paid a uniform reimbursement rate for service as established by the Department on an annual basis. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (3-21-12)
- O2. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical transportation, unless approved by the RMS under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as provided in Subsections 307.03 through 307.07 of these rules. (3-19-07)
- 03. Weighted Average Hourly Rates. Annually Medicaid will conduct a poll of all Idaho nursing facilities and ICFs/ID, and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, certified and non-certified nurse's aides) in Idaho to be used in calculating the reimbursement rate to be effective on July 1st of that year. (3-29-10)

04. Payment for Personal Assistance Agency.

(3-4-11)

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

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

(3-21-12)

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

 (3-21-12)
- c. Based on the survey conducted, provided that at least eighty-five percent (85%) of all Personal Assistance Agencies respond, the Department will calculate a supplemental component using costs reported for

travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. If less than eighty-five percent (85%) of all Personal Assistance Agencies respond, the rate will remain at the WAHR rate without the supplemental component. (3-4-11)

- **Payment Levels for Adults in Residential Care or Assisted Living Facilities or Certified Family Homes.** Adult participants living in Residential Care or Assisted Living Facilities (RCALF) or Certified Family Homes will receive personal care services at a rate based on their care level. Each level will convert to a specific number of hours of personal care services. (3-19-07)
- a. Reimbursement Level I -- One point twenty-five (1.25) hours of personal care services per day or eight point seventy-five (8.75) hours per week. (3-19-07)
- **b.** Reimbursement Level II -- One point five (1.5) hours of personal care services per day or ten point five (10.5) hours per week. (3-19-07)
- c. Reimbursement Level III -- Two point twenty-five (2.25) hours of personal care services per day or fifteen point seventy-five (15.75) hours per week. (3-19-07)
- d. Reimbursement Level IV One point seventy-nine (1.79) hours of personal care services per day or twelve point five (12.5) hours per week. This level will be assigned based on a documented diagnosis of mental illness, intellectual disability, or Alzheimer's disease. If an individual is assessed as Level III with a diagnosis of mental illness, intellectual disability, or Alzheimer's disease the provider reimbursement rate will be the higher amount as described in Subsection 307.05.c. of these rules. (3-19-07)
- 06. Attending Physician Reimbursement Level. The attending physician or authorized provider will be reimbursed for services provided using current payment levels and methodologies for other services provided to eligible participants. (3-19-07)
- **O7. Supervisory RN and QMRP Reimbursement Level.** The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Participant evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the RMS.

 (3-19-07)
- a. The number of supervisory visits by the RN or QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the RMS. (3-19-07)
- **b.** Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the RMS. (3-19-07)
- O8. Payment for PCS Family Alternate Care Home. The Department will establish PCS Family Alternate Care Home rates for personal assistance services based on the WAHR. Beginning with State Fiscal Year 2013, every five (5) years the Department will conduct a survey of all Personal Assistance Agency's which requests the number of hours of all Direct Care Staff and the indirect costs involved such as administration, and training. Based on the survey conducted, the Department will calculate a supplemental component using costs reported for administration, and training. The survey data is the cost information collected during the prior State Fiscal Year.

PCS Family Alternate Care Home	Children's PCS Assessment Weekly Hours x (WAHR x supplemental component)	=	\$ amount/week
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(3-21-12)

providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

- 22. Behavior Consultation or Crisis Management Service Providers. Behavior consultation or crisis management providers must meet the following: (3-30-07)
- a. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; (3-30-07)
 - b. Be a licensed pharmacist; or

(3-30-07)

- c. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D., with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and

 (3-30-07)
 - **d.** Take a traumatic brain injury training course approved by the Department.

(3-30-07)

- e. Emergency back-up providers must also meet the minimum provider qualifications under residential habilitation services. (3-30-07)
- f. Behavior consultation or crisis management service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

330. AGED OR DISABLED WAIVER SERVICES: PROVIDER REIMBURSEMENT.

The criteria used in reimbursing providers for waiver services are listed in Subsections 330.01 through 330.03 of these rules. (3-19-07)

- 01. Fee for Services. Waiver service providers will be paid on a fee for service basis as established by the Department depending on the type of service provided. Adult residential care will be paid on a per diem basis, based on the number of hours and types of assistance required by the participant as identified in the UAI. (3-19-07)
- **O2.** Provider Claims. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department's payment system contractor. (3-19-07)
- O3. Calculation of Fees. The fees calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided waiver or state plan transportation.

 (3-19-07)

331. -- 449. (RESERVED)

SUB AREA: HOSPICE (Sections 450 Through 459)

450. HOSPICE.

Medical assistance will provide payment for hospice services for eligible participants. Reimbursement will be based