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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 15-0008

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104

Division of Medicaid & Children's Health Operations

March 23, 2016

Denise Chuckovich, Deputy Director
Department of Health and Welfare
Towers Building - Tenth Floor
PO Box 83720
Boise, ID 83720-0036

RE: ID State Plan Amendment (SPA) Transmittal Number #15-0008 – Approval

Dear Ms. Chuckovich:

We have reviewed the proposed amendment to Attachment 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 15-0008. This SPA updates the payment methodology for hospice claims.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 15-0008 is approved effective as of January 10, 2016. For your files, we are enclosing the HCFA-179 transmittal form and the amended plan pages.

If there are any questions concerning this approval, please contact me or your staff may contact Tom Couch at Thomas.couch@cms.hhs.gov or (208) 861-9838.

Sincerely,

[redacted]

Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS, ou=CMS, ou=People, 0.9.2342.19200300.100.1.1=2000041858, cn=David L. Meacham -S
Date: 2016.03.23 12:34:57 -07'00'

David L. Meacham
Associate Regional Administrator

Enclosures

cc:
Lisa Hettinger, Department of Health and Welfare
Cale Coyle, Department of Health and Welfare
Dea Kellom, Department of Health and Welfare

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **15-0008**

2. STATE: **IDAHO**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~**01 January 2016**~~ **January 10, 2016 (P&I)**

5. TYPE OF PLAN MATERIAL *(Check One)*:
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1905(a)(6), 1905(a)(12) and 2110(a)(24) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
Total ($) Federal Funds
FFY 2016 – $149,000.90
FFY 2017 – $214,016.03

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Section 18, Pages 26-31

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Section 18, Pages 26-31

10. SUBJECT OF AMENDMENT:
The proposed changes will update our payment methodology for Hospice claims. For Hospice Routine Home Care claims with dates of service on or after 01 January 2016 will be paid one-of-two rates which will result in a higher base payment for the first sixty (60) days of hospice care and a reduced base payment rate for all days thereafter. Additionally a Service Intensity Add-on (SIA) payment, paid in conjunction with Routine Home Care, is being established. The SIA payment is for services provided by a registered nurse or social worker during the last seven (7) days of a beneficiary's life.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ **GOVERNOR'S OFFICE REPORTED NO COMMENT**
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
LISA HETTINGER

14. TITLE:
Administrator

15. DATE SUBMITTED:

16. RETURN TO:

Lisa Hettinger, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0009

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/29/2015

18. DATE APPROVED:
03/23/2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01/10/16

20. SIGNATURE OF [redacted]

Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS, ou=CMS, ou=People, 0.9.2342.19200300.100.1.1=2000041858, cn=David L. Meacham -S
Date: 2016.03.23 12:35:47 -07'00'

21. TYPED NAME:
David L. Meacham

22. TITLE:
Associate Regional Administrator

23. REMARKS:

P&I change to box 4 authorized by the state on 01/12/16.

FORM HCFA-179 (07-92)

18. HOSPICE SERVICES. With the exception of payment for physician services, Medicaid reimbursement for hospice care will be made at one (1) of five (5) predetermined rates for each day in which an individual receives the respective type and intensity of the services furnished under the care of the hospice. The five (5) rates are prospective rates; there will be no retroactive rate adjustments other than the application of the "cap" on overall payments and the limitation on payments for inpatient care, if applicable. A description of the payment for each level of care is as follows:

A. ROUTINE HOME CARE. The hospice will be paid one-of-two routine home care rate for each day the patient is in residence, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. The two-rate payment methodology will result in a higher base payment for days one (1) through sixty (60) of hospice care and a reduced rate for days sixty-one (61) and beyond. A minimum of sixty (60) days gap in hospice services is required to reset the counter, which determines which payment category a participant is qualified for.

B. CONTINUOUS HOME CARE. Continuous home care is to be provided only during a period of crisis. A period of crisis is the period in which a patient requires continuous care which is primarily nursing care to achieve palliation and management of acute medical symptoms. Either a registered nurse or a licensed practical nurse must provide care and a nurse must provide care for at least half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day, which begins and ends at midnight. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care. For every hour or part of an hour of continuous care furnished, the incremental rate will be reimbursed to the hospice up to twenty-four (24) hours per day (ninety-six [96] increments per day).

C. INPATIENT RESPITE CARE. The hospice will be paid at the inpatient respite care rate for each day the recipient is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five (5) days including the date of admission but not counting the date of discharge in any monthly election period. Payment for the sixth and any subsequent day is made at the routine home care rate. Inpatient respite care may be provided in hospital or nursing facility.

D. GENERAL INPATIENT CARE. Payment at the inpatient rate will be made when general inpatient care is provided. No other fixed payment rates will be applicable for a day on which the recipient receives hospice general in patient care except as described in the section of this plan, which discusses payment of physician services.

E. SERVICE INTENSITY ADD-ON. Effective 01 January 2016, payment for the Service Intensity Add-On (SIA) will be made for a visit by a registered nurse (RN) or Social Worker when provided in the last seven (7) days of life. Payment for the SIA will be calculated by multiplying the continuous home care (CHC) rate per 15 minutes by the number of units for the combined visits for the day (payment not to exceed 16 units) and

adjusted for geographic differences in wages. In addition, the time of the social worker's phone calls is not eligible for an SIA payment.

F. OTHER GENERAL REIMBURSEMENT ITEMS.

I. DATE OF DISCHARGE. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date.

II. HOSPICE PAYMENT RATES. Idaho pays the Medicaid hospice rates published by CMS on an annual basis. The rates are adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. Under the Medicaid hospice benefit, cost sharing may not be imposed with respect to hospice services rendered to Medicaid recipients.

G. OBLIGATION OF CONTINUING CARE. After the recipient's Medicare hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide the recipient's care until the patient expires or until the recipient revokes the election of hospice care.

H. LIMITATION ON PAYMENTS FOR INPATIENT CARE. Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve (12) month period beginning November 1 of each year and ending October 31 of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care) may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid recipients during the same period by the designated hospice or its contracted agent(s).

I. For purposes of computation, if it is determined the inpatient rate should not be paid then any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitations on payment for inpatient days are as follows:

1) The maximum number of allowable inpatient days will be calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%).

2) If the total number of days of inpatient care to Medicaid hospice patients is less than or equal to the maximum number of inpatient days computed, then no adjustment is made.

3) If the total number of days of inpatient care exceeds the maximum number of inpatient days computed, then the payment limitation will be determined by:

a) Calculating the ratio of the maximum allowable inpatient days to the number of actual days of inpatient care, and multiplying this ratio by the total

reimbursement for inpatient care that was made.

b) Multiplying excess inpatient care days by the routine home care rate.

c) Adding the amounts calculated in subparagraphs (1) and (2) above.

d) Comparing the amount in subparagraph (3) above with interim payments made to the hospice for inpatient care during the "cap period".

4) The amount by which interim payments for inpatient care exceeds the amount calculated in section (3)(d) is due from the hospice.

I. PAYMENT FOR PHYSICIAN SERVICES. The basic rates for hospice care represent full reimbursement to the hospice for the costs of all covered services related to the treatment of the recipient's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice. The physician serving as the medical director and the physician member of the hospice interdisciplinary group would generally perform these activities. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care.

I. Reimbursement for a hospice-employed physician's direct patient services, which are not rendered by a hospice volunteer, is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician's services. These services will be billed by the hospice under the hospice provider number and, the related payments will be counted in determining whether the overall hospice cap amount has been exceeded. The only physician services to be billed by a hospice for such services are direct patient care services. Laboratory and x—ray services are included in the hospice daily rate.

II. Volunteer physician services are excluded from Medicaid reimbursement with the following exceptions:

1) A hospice may be reimbursed on behalf of a volunteer physician for specific direct patient care services, which are not rendered on a volunteer basis. The hospice must have a liability to reimburse the physician for those services rendered. In determining whether a service is provided on a volunteer basis, a physician must not distinguish which services are provided voluntarily based on the patient's ability to pay.

2) Reimbursement for an independent physician's direct patient services, which are not rendered by a hospice volunteer, is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician services. These services will not be billed by the hospice under the hospice provider number and they will not

be counted in determining whether the overall hospice cap amount has been exceeded. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or x-rays are not to be included on the attending physician's billed charges to the Medicaid program. The aforementioned charges are included in the daily rates paid and are expressly the responsibility of the hospice.

J. CAP ON OVERALL REIMBURSEMENT. Aggregate payments to each hospice will be limited during a hospice cap period. The total payments made for services furnished to Medicaid recipients during this period will be compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice. The hospice aggregate cap amount is updated annually in accordance with Section 1814 (i)(2)(B) of the Act and provides for an increase (or decrease) in the hospice cap amount. The hospice wage index is used to adjust payment rates to reflect local differences in wages.

I. The overall cap will be compared to reimbursement after the inpatient limitation is computed and subtracted from total reimbursement due the hospice.

1) "Total payment made for services furnished to Medicaid recipients during this period" means all payments for services rendered during the cap year, regardless of when payment is actually made.

2) The "cap amount" is calculated in accordance with the methodology specified by Medicare and is adjusted annually.

3) The Department's Medical Assistance Unit determines the computation and application of the "cap amount" after the end of the cap period.

4) The hospice will report the number of Medicaid recipients electing hospice care during the period to the Department's Medical Assistance Unit. This must be done within thirty (30) days after the end of the cap period as follows:

5) If a hospice certifies in mid-month, a weighted average cap amount based on the number of days following within each cap period would be used.

K. ADJUSTMENT OF THE OVERALL CAP. Cap amounts in each hospice's cap period will be adjusted to reflect changes in the cap periods and designated hospices during a recipient's election period. The proportion of each hospice's days of service to the total numbered hospice days rendered to a recipient during their election period will be multiplied by the cap amount to determine each hospice's adjusted cap amount.

I. After each cap period has ended, the Department's Medical Assistance Unit will calculate the overall cap within a reasonable time for each hospice participating in the Idaho Medicaid Program.

II. Each hospice's cap amount will be computed as follows.

1) The share of the "cap amount" each hospice is allowed will be based on the proportion of total covered days provided by each hospice in the "cap period".

2) The proportion determined in Section (I) (2) (a) for each certified hospice will be multiplied by the "cap amount" specified f or the "cap period" in which the recipient first elected hospice.

3) The recipient must file an initial election during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing Medicaid recipient during the current cap year.

L. ADDITIONAL AMOUNT FOR SNF AND ICF RESIDENTS. An additional per diem amount will be paid for "room and board" of residents in a certified SNF or a certified ICF receiving routine or continuous care services. In this context, the term "room and board" includes, but is not limited to, all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies. The additional payments and the related days are not subject to the caps. The amount for room and board rate will be based per subsection 1902(a) (13) of the Social Security Act and will be at least equal to 95% of facility specific per diem rate.

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