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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 16-0005

This file contains the following documents in the order listed:

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

February 14, 2017

Lisa Hettinger, 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 #16-0005 – Approval

Dear Ms. Hettinger:

We have reviewed the proposed amendment to Attachment 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 16-0005. This SPA provides federally qualified health centers (FQHCs) and rural health centers (RHCs) with reimbursement for long acting reversible contraceptives (LARCs) and non-surgical trans-cervical permanent contraceptive devices outside of the encounter rate.

We conducted our review of the 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 16-0005 is approved with an effective date of July 1, 2016. We are enclosing the CMS-179 transmittal form and the amended plan pages for your records.

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,

Digitally signed by David L. Meacham -

[redacted]

David L. Meacham
Associate Regional Administrator

Enclosures

cc:
Cale Coyle, Idaho Department of Health and Welfare
Kaylee Leavitt, Idaho Department of Health and Welfare
Dea Kellom, Idaho 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: **16-0005**

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: **July 01, 2016**

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, 42 CFR 440.167, 1902(bb), 42 CFR 447.252 (P&I)

7. FEDERAL BUDGET IMPACT:
Total ($) Federal Funds
FFY 2016 – ~~$40,000.00~~ $31,837.62 (P&I)
FFY 2017 – ~~$40,000.00~~ $32,792.75 (P&I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~**Attachment 4.19-B, Pages 1.b-9**~~(P&I) **Attachment 4.19-B, Pages 2-9** (P&I)
Deleting page 1.b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Pages 1.b-9

10. SUBJECT OF AMENDMENT:
The proposed changes will allow federal qualified health centers (FQHCs) and rural health clinics (RHCs) to be reimbursed for Long Acting Reversible Contraceptives (LARCs) and non-surgical, transcervical permanent female contraceptive devices outside of the encounter rate.

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:
Medicaid Director

15. DATE SUBMITTED: 8/11/2016

16. RETURN TO:
Lisa Hettinger, Medicaid Director
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0009

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 8/11/2016

18. DATE APPROVED: 2/14/2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/2016

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]
Date: 2017.02.16 07:55:31 -08'00'

21. TYPED NAME: David L. Meacham

22. TITLE: Associate Regional Administrator

23. REMARKS:
10/14/16: State authorize P&I change to boxes 6, 7 and 8.

VI. Patient Education: Outpatient Hospital Diabetic Education and Training Program. Limited diabetic education and training services rendered through programs recognized by the American Diabetes Association, or provided by Certified Diabetes Educators are reimbursed at the lower of the provider's actual customary charge, or the allowable charge as established by the Department's fee schedule. The fee schedule and any annual/periodic adjustments to the fee schedule are published at: http://www.healthandwelfare.idaho.gov. The fee schedule was last updated on 07/01/16 to be effective for services on or after 07/01/16.

B. RURAL HEALTH CLINICS. A RHC is a facility located in a rural area designated as a shortage area, and is neither a rehabilitation agency nor a facility primarily for the care and treatment of mental diseases.

I. CARE AND SERVICES PROVIDED. RHC services are defined as follows:

1) Physician services; or
2) Services and supplies incidental to physician services including drugs and biologicals which cannot be self-administered; or
3) Physician assistant services; or
4) Nurse practitioner or clinical nurse specialist services, to include certified nurse midwives or visiting nurses; or
5) Clinical psychologist services; or
6) Clinical social worker services; or
7) Services and supplies incidental to a nurse practitioner, physician's assistant, clinical psychologist, or clinical social worker as would otherwise be covered if furnished by or incident to a physician service; or
8) In the case of a RHC located in an area which has a shortage of home health agencies, part-time or intermittent nursing care and related medical services to a homebound individual.

II. ENCOUNTER. An encounter is a face-to-face contact for the provision of a medical or mental service between a clinic patient and a physician, physician assistant, nurse practitioner, clinical nurse specialist, visiting nurse clinic social worker, clinical psychologist, or other specialized nurse practitioner.

1) Contacts with more than one (1) discipline of health professional (medical or mental) in the same day and in the same location constitute a separate encounter (limited to two (2) encounters per day). If the patient, subsequent to the first encounter suffers an illness or injury requiring additional diagnosis or treatment, it will be counted as a separate encounter. The health professional contacts are limited to individuals able to diagnose and treat physical and mental conditions.

a) A core service ordered by a health professional who did not perform an examination or treatment at the outset of the encounter which is subsequently delivered by support staff is considered a single encounter.

b) Multiple contacts with clinic staff of the same discipline (as defined above) on the same day related to the same illness or injury are considered a single encounter.

c) Services incidental to a billable encounter include in-house radiology, in-house laboratory services, injectable medications, medical equipment and supplies.

III. CONDITIONS OF PARTICIPATION. A qualified RHC applicant will be recognized as a Medicaid provider with the following stipulations:

1) The provider is confirmed as eligible by the Public Health Service and CMS on and after 04/01/90; and

2) The RHC applicant will simultaneously terminate its Medicaid FQHC and other Department specified Medicaid agreements from which the RHC may provide recipients with medical services and supplies at other than reasonable cost reimbursement.

3) Written agreements between the provider and subcontractors will require the subcontractors retain the related records for at least three (3) years after each provider's fiscal year end. The written agreements will assure access to records affecting Medicaid reimbursement by the Department, the Secretary of Health and Human Services, or their respective designee. The agreement will specify failure to maintain such records voids the agreement between the subcontractor and the provider.

IV. REIMBURSEMENT – GENERAL.
Payment for RHC services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

1) With the exception to services for Long Acting Reversible Contraception (LARC) and Non-surgical Transcervical Permanent Female Contraceptive Devices effective on or after 07/01/16, all RHC services are reimbursed on a prospective payment system for services furnished on or after 01/01/01 and each succeeding fiscal year.

2) An encounter rate will be established for medical/mental encounters. These encounter rates will be set up prospectively using the center's reasonable medical/ mental costs determined by the audited cost report for fiscal years 1999 and 2000. The costs for each of these periods will be divided by the total number of encounters for each period to arrive at a cost per encounter. These encounter rates will be inflated from the mid-point of the cost reporting period to the mid-point of the perspective rate period using the Medicare Economic Index (MEI). The average of these two rates will be the prospective medical/mental rates for the period 01/01/01 to 09/30/01.

3) Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each center is paid the amount (on a per medical/mental encounter basis) equal to the amount paid in the previous federal fiscal year, increased by the percentage increase in the MEI for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the center during that fiscal year. The RHC is responsible for supplying the needed documentation to the State regarding increase or decrease in the RHC scope of services. The per encounter payment rate shall include costs of all Medicaid coverable services and costs provided in the center.

4) A change in the scope of services is defined to include such things as addition of new service, deletion of existing service, or other changes in the scope/intensity of services offered by a clinic which could significantly change a clinics total allowable cost per encounter. The Division of Medicaid or its designee will make the final determination whether or not there has been a change in the scope of services.

5) For newly qualified RHCs after federal fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers and adjustment for any increase/decrease in the scope of services furnished by the center during that fiscal year.

    a) In the case of any RHC which contracts with a managed care organization, supplemental payments will be made quarterly to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system to ensure compliance with Section 1902(bb)(5)(B) of the SSA.

6) The Medicaid payment for case management under the Healthy Connections program, and for presumptive eligibility screenings shall be included in the encounter rate calculation, however shall be reimbursed separately from the encounter.

7) Effective 07/01/16, reimbursement for Long Acting Reversible Contraception (LARC) and Non-surgical Transcervical Permanent Female Contraceptive Devices shall be separate from the RHC PPS rate. In addition to payment at the PPS rate for the insertion of the device(s), RHCs will be eligible for payment for cost of the device(s) for claims with dates of service on or after 07/01/16 to be paid at the 340B acquisition cost. For device(s) not purchased through the 340B program, reimbursement shall be made at the lower of the provider's charges or the rate on the fee schedule posted at: http://www.healthandwelfare.idaho.gov. The fee schedule was last updated on 07/01/16 to be effective for services on or after 07/01/16.

8) *PAYMENT METHODOLOGY FOR MANAGED CARE SERVICES*
To ensure appropriate amounts are paid to each RHC, Idaho Medicaid will perform quarterly reconciliations and verify the PPS payments made in the prior quarter were in compliance with Section 1902(bb)(5)(B). The reconciliation for each quarter's reconciliation will start in the following quarter. This process will apply to all contracted managed care services for RHCs. The quarterly reconciliation will be done as follows:

a) PROSPECTIVE PAYMENT SYSTEM (PPS)
(managed care encounters X PPS encounter rate) less (fee for service equivalent) = State's payment amount

b) MEDICARE-MEDICAID COORDINATED PLAN
For services provided at a RHC to participants enrolled with a managed care contractor for the Medicare-Medicaid Coordinated Plan, the State will be conducting quarterly reconciliations to ensure compliance with Section 1902(bb)(5)(B) of the SSA.

c) NON-MEDICARE-MEDICAID COORDINATED PLAN
For services provided at a RHC to participants not enrolled with a managed care contractor for the Medicare-Medicaid Coordinated Plan, the State will reimburse the RHC using an alternative payment methodology (APM) administered in accordance with Section 1902(bb)(6) of the SSA. The APM requires the managed care contractors to pay RHC encounters in accordance with the state's reimbursement methodology (PPS). The requirement to use the PPS methodology results in payment to the RHC of an amount which is at least equal to the amount otherwise required to be paid, and this methodology is already agreed to by the State and the RHC. These two provisions are in accordance with Section 1902(bb)(6) of the SSA. The State will be conducting quarterly reconciliations to ensure compliance with Section 1902(bb)(5)(B) of the SSA.

C. FEDERALLY QUALIFIED HEALTH CENTER (FQHC). Effective retroactively to 04/01/90, FQHCs are defined as community health centers, migrant health centers, providers of care for the homeless, outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-determination Act, as well as clinics which qualify but are not actually receiving grant funds under section 329, 330, or 340 of the Public Health Service Act may provide ambulatory services to Medical Assistance recipients.

I. CARE AND SERVICES PROVIDED. FQHC services are defined as follows:

1) Physician services; or
2) Services and supplies incidental to physician services including drugs and biologicals which cannot be self-administered; or
3) Physician assistant services; or
4) Nurse practitioner or clinical nurse specialist services to include certified nurse midwives or visiting nurses; or
5) Clinical psychologist services; or
6) Clinical social worker services; or
7) Services and supplies incidental to a nurse practitioner, physician's assistant, clinical psychologist, clinical social worker, dentist, or dental hygienist services as would otherwise be covered if furnished by or incident to a physician service; or
8) Dental services including both the licensed dentist and dental hygienist; or
9) In the case of a FQHC located in an area which has a shortage of home health agencies, part-time or intermittent nursing care and related medical services to a home bound individual; and
10) Other Title XIX payable ambulatory services offered by the Idaho Medicaid program which the FQHC undertakes to provide; including pneumococcal or immunization vaccine and its administration.

II. ENCOUNTER. An encounter is a face-to-face contact for the provision of medical, mental, or dental service between a clinic patient and a physician, physician assistant, nurse practitioner, clinical nurse specialist, visiting nurse clinic social worker, clinical psychologist, other specialized nurse practitioner, dentist, or dental hygienist.

1) Contacts with more than one (1) discipline of health professional (medical, mental, or dental) in the same day and in the same location constitute a separate encounter (limited to three (3) encounters per day). If the patient, subsequent to the first encounter suffers an illness or injury requiring additional diagnosis or treatment, it will be counted as a separate encounter. The health professional contacts are limited to individuals able to diagnose and treat physical, mental, and dental health issues.

a) A core service ordered by a health professional who did not perform an examination or treatment at the outset of the encounter which is subsequently delivered by support staff is considered a single encounter.

b) Multiple contacts with clinic staff of the same discipline (as defined above) on the same day related to the same illness or injury are considered a single encounter.

c) Services incidental to a billable encounter include in-house radiology, physical therapy, occupational therapy, speech therapy, Audiology services, in-house laboratory services, in-house nutritional education or dietary counseling and monitoring by a registered dietician, injectable medications, medical equipment and supplies.

III. CONDITIONS OF PARTICIPATION. A qualified FQHC applicant will be recognized as a Medicaid provider with the following stipulations:

1) The provider is confirmed as eligible by the Public Health Service and CMS on and after 04/01/90; and

2) The FQHC applicant will simultaneously terminate its Medicaid RHC and other Department specified Medicaid agreements from which the FQHC may provide recipients with medical services and supplies at other than reasonable cost reimbursement.

3) Written agreements between the provider and subcontractors will require the subcontractors retain the related records for at least three (3) years after each provider's fiscal year end. The written agreements will assure access to records affecting Medicaid reimbursement by the Department, the Secretary of Health and Human Services, or their respective designee. The agreement will specify failure to maintain such records voids the agreement between the subcontractor and the provider.

IV. REIMBURSEMENT – GENERAL.
Payment for FQHC services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

1) With the exception to services for Long Acting Reversible Contraception (LARC) and Non-surgical Transcervical Permanent Female Contraceptive Devices effective on or after 07/01/16, all FQHC services are reimbursed on a prospective payment system for services furnished on or after 01/01/01 and each succeeding fiscal year.

2) An encounter rate will be established for medical/mental and dental encounters separately. These encounter rates will be set up prospectively using the center's reasonable medical/mental and dental costs determined by the audited cost report for fiscal years 1999 and 2000. The costs for each of these periods will be divided by the total number of encounters for each period to arrive at a cost per encounter. These encounter rates will be inflated from the mid-point of the cost

reporting period to the mid-point of the prospective rate period using the Medicare Economic Index (MEI). The average of these two rates will be the prospective medical/mental and dental rates for the period 01/01/01 to 09/30/01.

3) Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each center is paid the amount (on a per medical/mental and dental encounter basis) equal to the amount paid in the previous federal fiscal year, increased by the percentage increase in the MEI for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the center during that fiscal year. The FQHC is responsible for supplying the needed documentation to the State regarding increase or decrease in the FQHC scope of services. The per encounter payment rate shall include costs of all Medicaid coverable services and costs provided in the center.

4) A change in the scope of services is defined to include such things as addition of new service, deletion of existing service, or other changes in the scope/intensity of services offered by a clinic which could significantly change a clinics total allowable cost per encounter. The Division of Medicaid or its designee will make the final determination whether or not there has been a change in the scope of services.

5) For newly qualified FQHCs after federal fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers and adjustment for any increase/decrease in the scope of services furnished by the center during that fiscal year.

    a) In the case of any FQHC which contracts with a managed care organization, supplemental payments will be made quarterly to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system to ensure compliance with Section 1902(bb)(5)(B) of the SSA.

6) The Medicaid payment for case management under the Healthy Connections program, and for presumptive eligibility screenings shall be included in the encounter rate calculation, however shall be reimbursed separately from the encounter.

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the rate on the fee schedule posted at: http://www.healthandwelfare.idaho.gov. The fee schedule was last updated on 07/01/16 to be effective for services on or after 07/01/16.

8) *PAYMENT METHODOLOGY FOR MANAGED CARE SERVICES*
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(managed care encounters X PPS encounter rate) less (fee for service equivalent) = State's payment amount.

b) MEDICARE-MEDICAID COORDINATED PLAN
For services provided at a FQHC to participants enrolled with a managed care contractor for the Medicare-Medicaid Coordinated Plan, the State will be conducting quarterly reconciliations to ensure compliance with Section 1902(bb)(5)(B) of the SSA.

c) NON-MEDICARE-MEDICAID COORDINATED PLAN
For services provided at a FQHC to participants not enrolled with a managed care contractor for the Medicare-Medicaid Coordinated Plan, the State will reimburse the RHC using an alternative payment methodology (APM) administered in accordance with Section 1902(bb)(6) of the SSA. The APM requires the managed care contractors to pay RHC encounters in accordance with the state's reimbursement methodology (PPS). The requirement to use the PPS methodology results in payment to the FQHC of an amount which is at least equal to the amount otherwise required to be paid, and this methodology is already agreed to by the State and the FQHC. These two provisions are in accordance with Section 1902(bb)(6) of the SSA. The State will be conducting quarterly reconciliations to ensure compliance with Section 1902(bb)(5)(B) of the SSA.