MedicAide

An Informational Newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid **December 2024**

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The content of this guidance document is not new law but is an interpretation of existing law prepared by the Idaho Department of Health and Welfare to provide clarity to the public regarding existing requirements under the law. This document does not bind the public, except as authorized by law or as incorporated into a contract. For additional information or to provide input on this document, contact the Idaho Division of Medicaid by emailing medicaidcommunications@dhw.idaho.gov or by calling (208)334-5747.

Anti-Kickback Statute

Medicaid providers who submit claims for reimbursement are required to provide and bill services in accordance with all applicable provisions of Idaho Statute, administrative code, and federal regulations under the Medical Assistance Program ("Medicaid").

The Medicaid Program Integrity Unit (MPIU) reviews services billed to Medicaid to ensure providers have been paid in accordance with Medicaid rules and regulations. MPIU works closely with the Medicaid Fraud Control Unit and refers credible allegations of fraud to them for further investigation.

Idaho Administrative Code 16.05.07.100.01 describes investigative methods and states"…the Department will investigate and identify potential instances of fraud, abuse, or other misconduct by any person related to or involved in public assistance programs administered by the Department.

The Anti-Kickback Statute (AKS) 42 U.S.C. § 1320a-7b(b)is a criminal law that prohibits the knowing and willful payment of "renumeration" to induce or reward patient referrals or the generation of business involving items or services payable by Federal healthcare programs.

Renumeration may be anything of value and can be received in multiple forms other than cash payments. Some examples are free rent, hotel accommodations, meals, gift cards, and excessive compensation for medical directorships and consultancies. In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. It is illegal to take money from providers and suppliers in return for referring Medicare and Medicaid patients. It is also illegal to pay others to refer their Medicare and Medicaid patients to you. The kickback prohibition also applies to patients. Routinely waiving co-payments is also a violation. However, co-payments may be waived on a case-by-case basis when following the guidance in the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook.

The beneficiary inducement statute (42 USC § 1320a-7a(a)(5)) also imposes civil monetary penalties on physicians who offer renumeration to Medicare and Medicaid beneficiaries to influence them to use their services.

Criminal penalties and administrative sanctions for violating the AKS include fines, jail terms, and exclusion from participation in Federal healthcare programs. Under the Civil Monetary Penalties Law, physicians who pay or accept kickbacks also face penalties up to $50,000 per kickback plus three times the amount of the remuneration.

Diabetes Education and Training

Idaho Medicaid is updating its coverage of the diabetes education and training to allow virtual care delivery. More information about coverage of this service can be found in the Physician and Non-Physician Practitioner, Idaho Medicaid Provider Handbook.

Attention Therapy Providers

Idaho Medicaid is discontinuing the separate fee schedule for independent therapy providers. Occupational and physical therapists, and speech-language pathologists should use the main

Numerical Fee Schedule for rates. Lists of covered codes for therapists can be found in the Therapy Services, Idaho Medicaid Provider Handbook

Provider Handbook Updates

The following Idaho Medicaid Provider Handbook updates have been published.

The General Billing Instructions handbook was updated in November to add the EP and TL modifiers.

The Hospital handbook was updated in November to:

- Updated Chimeric Antigen Receptor Therapy billing codes; and
- Add revenue codes for electroconvulsive therapy and outpatient behavioral health.

The Physician and Non-Physician Practitioner handbook was updated in November to:

- Clarify hysterectomies using Sterilization Forms must be completed before the procedure; and
- Allow virtual care delivery for diabetes education and training.

Questions about this article or suggestions about the provider handbook may be submitted to the Medicaid Policy Team at MCPT@dhw.idaho.gov.

Upcoming Provider Meetings

Idaho Medicaid will be holding provider meetings in December.

DMEPOS Providers
Topics: Wheelchair Seating and Mobility Evaluation Open Forum
Tuesday, December 3, 2024 – 10:30 am (MT)/9:30 (PT)
Webinar Information & Meeting Link
https://idhw.webex.com/idhw/j.php?MTID=mec27d7ab4a5293ec1959b5579d85217c
Join by phone: 1-415-527-5035
Join by meeting number: 2830 549 3253
Meeting Password: zUhq6VdVK32 (98476838 from phones and video systems)
Email for invite: MCPT@dhw.idaho.gov

Therapy Providers
Topics: Documentation Evaluation Supervision of Assistants Open Forum
Tuesday, December 10, 2024 – 10:30 am (MT)/9:30 am (PT)
Webinar Information & Meeting Link
https://idhw.webex.com/idhw/j.php?MTID=mcf0a2f70dd242e9f5577e236c43ec56b
Join by Phone: 1-415-527-5035
Join by meeting number: 2823 646 5610
Meeting Password: WmwYpCNm284 (76336596 from phones and video systems)
Email for invite: MCPT@dhw.idaho.gov

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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November 13, 2024

MEDICAID INFORMATION RELEASE MA24-26

To: All Medicaid Providers

From: Juliet Charron, Deputy Director

Subject: Update to the Medicaid Provider Agreement

Idaho Medicaid is updating the terms of the Medicaid Provider Agreement (attached). Per the terms of the Medicaid Provider Agreement, section 1. Compliance:

> *"The DEPARTMENT reserves the right to amend this AGREEMENT by providing the PROVIDER twenty-eight (28) day notice, as published within an Information Release (IR), and PROVIDER is deemed to accept, following such notice period. This AGREEMENT will be deemed modified, revised, or terminated to comply with any change on the effective date of such change."*

This updated agreement primarily changes language around the provision of insurance information in section 7.4. Professionalism.

> *PROVIDER attests compliance with all requirements to maintain appropriate insurance coverage as applicable within the scope of their professional license/certification and services rendered.*

This version will apply to Medicaid providers enrolling with fee-for-service Medicaid for reimbursement and includes those that may also provide services under a managed care organization. The updated Medicaid Provider Agreement will be effective December 1, 2024. This is not the date managed care providers are required to begin enrollment. Providers enrolling to provide services for ordering, referring and prescribing providers, and all managed care providers, who are only enrolling to provide services with the managed care organization should review Information Release MA24-27 ORP Only Provider Agreement Update.

Idaho Medicaid will be implementing a phased roll-out for the required enrollment of managed care providers at a later time. Idaho Medicaid will notify providers at least sixty (60) days prior to this requirement being effective. We will do everything we can to provide

timely and comprehensive information, reduce confusion, and minimize administrative burden as much as possible.

Specific questions not answered by the materials referenced above can be directed to MCPT@dhw.idaho.gov.

JC/wd

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TERMS AND CONDITIONS

1. Compliance.

This Provider Agreement ("AGREEMENT") is entered into by and between the Department of Health and Welfare ("DEPARTMENT"), as the State of Idaho's administering agency with authority under Idaho Code, Title 56, Chapter 2, to enter into agreements with individuals or entities ("PROVIDER"). This AGREEMENT is entered into for the purpose of defining the DEPARTMENT's expectations of providers who provide healthcare services, equipment, supplies or items and hereinafter referenced as "SERVICES" through any network to persons eligible for medical assistance and who submit claims for reimbursement in accordance with all applicable provisions of Idaho Statute, administrative code and federal regulations under the Medical Assistance Program ("MEDICAID"). This AGREEMENT and the terms herein are conditions of payment as used in Section 56-§209h (5) of Idaho Code. Failure to comply with any of the Terms and Conditions, or applicable ADDENDUMS incorporated herein, may affect PROVIDER's ability to continue participation in MEDICAID or may result in recovery of payments made by the DEPARTMENT to the PROVIDER, assessment of civil monetary penalties, suspension of payments and/or exclusion from the Medicaid program.

This AGREEMENT and any applicable ADDENDUMS attached hereto and hereby incorporated by reference; are subject to modification, revisions, or termination in accordance with changes in federal or state laws, administrative code or regulations. The DEPARTMENT reserves the right to amend this AGREEMENT by providing the PROVIDER twenty-eight (28) day notice, as published within an Information Release (IR), and PROVIDER is deemed to accept, following such notice period. This AGREEMENT will be deemed modified, revised, or terminated to comply with any change on the effective date of such change.

This AGREEMENT delineates the responsibilities of the PROVIDER and any subcontractor, agent or employee of the PROVIDER, in regard to the MEDICAID Program. The PROVIDER certifies and agrees to the Terms and Conditions set forth below.

2. Regulations, Rules, Policies and Procedures.

2.1 PROVIDER certifies that SERVICES provided will be provided to participants without regard to health status or need for healthcare services and will be provided without regard to race, color, age, sex, disability, or national origin in accordance with 45 CFR Part 90, Part 91 and Part 92 and 42 CFR Part 438, as applicable and as amended.

2.2 PROVIDER shall comply with all applicable provisions of 45 CFR Part 88, consistent with applicable court orders or as amended; the Health Insurance Portability and Accountability Act (HIPAA); Sections 262 and 264 of Public Law 104 -191, 42 USC Section 1320d, and applicable federal regulations at 45 CFR Subchapter C specific to Administrative Data Standards and 45 CFR Subchapter D - Health Information Technology and Related Requirements;170.215. PROVIDER shall additionally be responsible for protecting the confidentiality of participant information that is collected, used, or maintained according to IDAPA 16.05.01, "Use and Disclosure of Department Records," and 42 CFR § 431. Subpart F specific to unauthorized disclosure of applicant and beneficiary information.

2.3 PROVIDER shall comply with 42 USC §1396A(a)(68) and 42 CFR §438.600(a)(6,) as amended and applicable, if PROVIDER receives or makes annual payments of MEDICAID funds of at least five million dollars ($5,000,000).

2.4 PROVIDER shall ensure any individual providing interpretive SERVICES related to the provision of a health-related service, is a minimum of eighteen (18) years of age and meets the definition of qualified interpreter consistent with 28 CFR § 35.104.

2.5 Pursuant to 42 CFR § 431.107, PROVIDER acknowledges their compliance with all requirements specific to AGREEMENTS, as applicable and amended, and Advance Directives, as applicable and specified in 42 CFR Part 489, Subpart I and 42 CFR §417.436(d), as amended.

2.6 PROVIDER acknowledges the responsibility to comply with all applicable parts of the False Claims Act (31 USC §§3729-3733) and 42 CFR §438.608(a)(6) as amended, including, but not limited to, educating employees about federal and State laws pertaining to civil or criminal penalties for false claims, false statements and whistleblower protections under such laws.

2.7 Pursuant to federal regulations at 42 CFR §455.105, PROVIDER shall if requested, furnish to the DEPARTMENT and/or the U.S. Department of Health and Human Services, within thirty-five (35) days of the date of the transaction or the date of the written request, full and complete information related to certain business transactions, specifically:

2.7.1 ownership of any subcontractor with whom the PROVIDER has had business transactions totaling more than $25,000 during the twelve (12) month period preceding the most recent business transaction or ending on the date of the request, as applicable; and

2.7.2 pursuant to 42 CFR Part 455, Subpart B, any significant business transaction, between the PROVIDER and any wholly owned supplier, or between the PROVIDER and any subcontractor, during the 5-year period preceding the most recent business transaction or ending on the date of the request.

2.8 PROVIDER certifies that SERVICES provided to participant are not in violation of Idaho Code § 18-8901.

3. Administrative Code.

PROVIDER shall comply with all applicable provisions of the Idaho Administrative Code, as amended, including but not limited to: IDAPA 16.03.01 - "Eligibility for Health Care Assistance for Families and Children", IDAPA 16.03.05 – "Eligibility for Aid to the Aged, Blind, and Disabled", IDAPA 16.03.09 – "Medicaid Basic Plan Benefits", IDAPA 16.03.10 – "Medicaid Enhanced Plan Benefits", IDAPA, 16.03.13 – "Consumer Directed Services", IDAPA 16.03.17 – "Medicare/Medicaid Coordinated Plan Benefits", and IDAPA 16.03.18 – "Medicaid Cost Sharing", IDAPA – 16.05.03 "Contested Case Proceedings and Declaratory Rulings", IDAPA 16.05.06 "Criminal History and Background Checks", and IDAPA 16.05.07 – "The Investigation and Enforcement of Fraud, Abuse and Misconduct."

4. Policy Guidance.

PROVIDER shall conduct operations in accordance with all applicable policy and guidance accessible to them via the internet at www.idmedicaid.com and healthandwelfare.idaho.gov, including, but not limited to, the MedicAide newsletter, Information Releases, the Idaho Medicaid Provider Handbook (Provider Manual), as applicable and amended. Additionally, PROVIDERS participating in a managed care program must adhere to applicable interpretations of policy specified by the managed care program.

5. Employee Training.

PROVIDER acknowledges responsibility to ensure employees, subcontractors and agents of the PROVIDER receive training specific to the usage and adherence of all applicable provisions of policy within this AGREEMENT for PROVIDERS providing services in any delivery system and by any mode including but not

limited to, all applicable IDAPA rules, policy documents and guidance contained within the MedicAide newsletter, Information Releases, the Idaho Medicaid Provider Handbook (Provider Manual), and managed care program contracts as amended and applicable.

6. Provider Enrollment Process.

6.1 PROVIDER shall comply with the DEPARTMENT's enrollment processes and acknowledges the DEPARTMENT's authority to make provider enrollment decisions, which may include but is not limited to, mandatory denial of a Provider Agreement in accordance with IDAPA 16.03.09.200.06. PROVIDER acknowledges and agrees PROVIDER and its principals will be held responsible for violations of this AGREEMENT through any acts or omissions by the PROVIDER, its employees, its subcontractors or its agents specific to the provider enrollment process, including but not limited to, failure to disclose the revocation, termination or voluntary termination of an enrollment or if any party specified within 42 CFR § 455.106(c) has been convicted of a criminal offense.

6.1.1 PROVIDER understands this includes all applicable disclosures provided within 42 CFR §422.104 applicable to relationships between those who have an ownership interest, a control interest operational or managerial control of the PROVIDER organization as applicable.

6.1.2 Pursuant to federal regulations at 42 CFR Part 455, Subpart B, "Disclosure of Information by Providers and Fiscal Agents" and by reference 42 CFR §438.602(c) as applicable PROVIDER shall comply with the disclosure of ownership requirements; and agrees that for the purposes of this AGREEMENT, principal of the PROVIDER includes all agents, corporate officers, directors, partners of any partnership entity, including a professional corporation, association, limited liability company, those participating through a managed care program or their fiscal agent with either indirect ownership or control interest.

6.1.3 PROVIDER understands they may make agreements to provide SERVICES through a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP) and acknowledge their responsibility under such agreements to comply with all applicable parts of 42 CFR Part 438, as amended in addition to all applicable provisions of this AGREEMENT.

6.1.3.1 PROVIDER further acknowledges this AGREEMENT must be approved within one hundred twenty (120) days if applicable, for enrollment or credentialing with an MCO, PIHP or PAHP, in accordance with 42 CFR §438.602.

6.1.3.2 PROVIDER understands that if rendering services only under an agreement with an MCO, PIHP or PAHP, PROVIDER is not required to render services to participants in the FFS network as provided by 42 CFR §438.608(b).

6.2 PROVIDER acknowledges this AGREEMENT is not transferable or assignable. PROVIDER also acknowledges that at any time during the course of this AGREEMENT, PROVIDER shall notify the DEPARTMENT of any change in information contained in this AGREEMENT or their Provider Enrollment application, including within thirty-five (35) days after the change. Changes PROVIDERs are required to report include, but are not limited to, changes (or impending changes) in ownership or control information described in 42 CFR 455 Subpart B; indirect ownership, service locations, changes to licensure, tax information, bankruptcy; physical, mailing or electronic addresses, phone number; or the addition or removal of Licensed Medical Service

Providers. Change in ownership or control information requires full disclosure of the terms of the sale agreement, submittal of a new enrollment application and execution of a new AGREEMENT.

7. **Professionalism.**

7.1 PROVIDER shall provide SERVICES in accordance with all applicable requirements within, Idaho state statutes, Idaho Administrative Code And 42 CFR Part 438 Managed Care.

7.2 PROVIDER shall obtain and maintain licenses, permits, certification, registration and authority necessary to conduct business and provide service under this AGREEMENT and 42 CFR Part 438 Managed Care, as applicable. Copies of these must be submitted to Gainwell's Provider Enrollment upon request.

7.3 PROVIDER shall comply with all applicable state and federal laws.

7.4 PROVIDER attests compliance with all requirements to maintain appropriate insurance coverage as applicable within the scope of their professional license/certification and services rendered.

7.5 PROVIDER agrees to uphold professionally recognized community standards of care and if applicable, retain non-Physician practitioners or paraprofessionals who have appropriate qualifications, licensing or certification as specified by the DEPARTMENT or a contract under 42 CFR Part 438 Managed Care. PROVIDER additionally agrees to provide appropriate supervision of such individuals.

7.6 PROVIDERs shall verify and ensure all employees, subcontractors and agents meet the fingerprint-based Criminal History Background Check provisions, as required by the DEPARTMENT under IDAPA 16.05.06, "Criminal History and Background Checks" and IDAPA, 16.03.09 "Medicaid Basic Plan Benefits".

7.7 PROVIDER shall abide by all applicable laws regarding the Medicaid participant's right to privacy, dignity, and free choice of providers and agrees to comply with 42 CFR, Chapter I, Subchapter A, Part 2 specific to Confidentiality of Substance Use Disorder Patient Records and 45 CFR, §164.524, as amended to afford access to records for SERVICES.

7.8 PROVIDER shall abide by this AGREEMENT and any applicable Addendums or supplemental agreements, as amended.

8. **Records Management.**

8.1 PROVIDER agrees to legibly document all SERVICES in accordance with professionally recognized standards to support each claim for reimbursement by MEDICAID or its agent, at the time it is provided, in compliance with the requirements specified in the Idaho Medicaid Provider Handbook (Provider Manual), Idaho Code, §56-209h(3), applicable DEPARTMENT rules and this AGREEMENT, as amended. Such documentation shall be maintained for at least five years after the date of service, in accordance with IDAPA 16.05.07.101 or as required by other DEPARTMENT rule. Failure to comply with documentation requirements may result in the recoupment of Medicaid payments.

8.2 PROVIDER shall ensure their cooperation with the DEPARTMENT's Medicaid Program Integrity Unit (MPIU), the Attorney General's Medicaid Fraud Control Unit and the U.S. Department of Health and Human Services, or their agents by providing immediate access in accordance with Idaho Code §56-209h and IDAPA 16.05.07 "The Investigation and Enforcement of Fraud, Abuse and Misconduct" to all records, documents, material, and data in any medium which supports SERVICES billed to MEDICAID or its designee, at the time the request is made.

8.2.1 PROVIDER also agrees to comply with applicable Quality Assurance audits specific to IDAPA 16.03.10, and as provided by any ADDENDUM to this AGREEMENT or agreement in a managed care program.

9. Accurate Billing.

9.1 PROVIDER shall certify by their signature or through their designee, including electronic signatures on a claim form or transmittal document, that the SERVICES claimed were actually provided in accordance with professionally recognized standards of health care, the Idaho Medicaid Provider Handbook (Provider Manual), all applicable DEPARTMENT rules, and this AGREEMENT.

9.2 PROVIDER agrees to be responsible for the accuracy of claims submitted to the DEPARTMENT or its agent whether submitted on paper, electronically or through a billing service.

9.3 PROVIDER ensures SERVICES are claimed only under one program and one provider type regardless of the delivery system or mode of delivery and to immediately repay the DEPARTMENT or its designee for any SERVICE the DEPARTMENT or the PROVIDER determines were not properly provided, properly documented, or properly claimed.

9.4 Pursuant to 42 USC §1320a-7 and 42 USC §1320c-5, PROVIDER shall bill MEDICAID or its agent only for SERVICES delivered by individuals not excluded from MEDICAID; and additionally, assures all payments are correctly applied to participant accounts and credited timely.

10. Secondary Payor or Third-Party Liability.

10.1 PROVIDER agrees to seek payment first from all other applicable sources of payment prior to submitting a claim for SERVICES to MEDICAID or its agent specific to 42 CFR §433 - Subpart D. for third party liability. Additionally, PROVIDER acknowledges MEDICAID as the payer of last resort and agrees to comply with 42 CFR §447.20(b).

10.1.1 As an exception to 10.1, Indian Health Services (IHS), purchased or referred care healthcare (PRC) by IHS, and health insurance plans self-funded by a federally recognized tribe are secondary to MEDICAID according to 42 CFR §136.203.

10.2 PROVIDER acknowledges that if a secondary payor or third party pays the participant for the SERVICES provided, the PROVIDER may bill the participant for that amount if written notice of financial responsibility was provided in accordance with MEDICAID policy and prior to the delivery of the service; and

10.3 PROVIDER acknowledges they cannot refuse to furnish SERVICES to a participant if a third-party is potentially liable for the service.

10.4 PROVIDER agrees to not bill the DEPARTMENT or its agent if a secondary payor or third-party payment is made to the PROVIDER, unless the secondary payor or third-party payment is less than the amount paid by MEDICAID or its agent.

11. Reimbursement.

11.1 PROVIDER understands they are to complete the appropriate claim form and acknowledges responsibility for the validity and accuracy of claims whether submitted on paper, electronically or through a billing service to MEDICAID or the DEPARTMENT's agent for reimbursement.

11.2 PROVIDER agrees to submit a request for prior authorization, if one is required, and to receive an approval for that request, prior to providing the requested SERVICES to the participant except where allowed by MEDICAID or its agent.

11.3 PROVIDER understands that reimbursement for the SERVICES by MEDICAID or its agent is contingent on the PROVIDER being correctly enrolled, licensed and credentialed, if applicable; conducting a determination of medical necessity for the SERVICES that meets all DEPARTMENT requirements or its agent if applicable; eligibility of the participant for the SERVICES at the time it is rendered; coverage limitations at the time provided; timely submittal of prior authorization when applicable; and the PROVIDER billing per all applicable requirements, including but not limited to administrative code, policies and requirements specified by the National Correct Coding Initiative.

12. Payment in Full.

12.1 Pursuant to 42 CFR §447.15 PROVIDER agrees to accept MEDICAID payment or payment by its agent, as payment in full, for any SERVICES.

12.1.1 PROVIDER also agrees that prior to delivering non-covered or excluded MEDICAID SERVICES to a participant, PROVIDER will supply an itemized written notice to the participant, which informs them of their responsibility to pay for the SERVICES they are receiving, prior to rendering the SERVICES and require the participant to affix their signature as acknowledgement of their financial responsibility. If the participant qualifies for a period of retroactive eligibility for Medicaid, this subsection does not apply during the retroactive period.

12.1.2 PROVIDER agrees to comply with the billing requirements specific to participant financial responsibility as provided within the Idaho Medicaid Provider Handbook (Provider Manual), administrative code or by a managed care program, as applicable.

13. Officers and Employees of the State.

PROVIDER acknowledges that no official, employee, or agent of the DEPARTMENT shall be in any way personally liable or responsible for any term of this AGREEMENT, whether express or implied, nor for any statement, representation, or warranty made in connection with this AGREEMENT. A guarantee of payment for SERVICES cannot be made by an official, employee or agent of the DEPARTMENT.

14. Provider Liability.

PROVIDER agrees if their organization is any type of business entity, the entity and all general or limited partnership interests and all shareholders, with a direct or indirect ownership or control interest, regardless of the percentage of ownership, are jointly and severally liable for any breach of this AGREEMENT, and that action by the DEPARTMENT against the PROVIDER may result in action against any or all such individuals in the entity.

15. Provider Revalidation.

15.1 PROVIDER acknowledges that the DEPARTMENT requires all enrolled providers to revalidate enrollment information at least every five years, in accordance with 42 CFR §455.414 and 42 CFR §438.602(b) if applicable. PROVIDER also acknowledges the DEPARTMENT may conduct off-cycle revalidations for certain program integrity purposes as allowed by 42 CFR §455.452 to ensure compliance with these requirements. Upon the DEPARTMENT's request to revalidate its enrollment, the PROVIDER has ninety (90) days from the postmark on the Revalidation Notice to submit the completed enrollment to the DEPARTMENT for approval.

15.2 PROVIDER also acknowledges all information disclosed by the PROVIDER is subject to verification. Any deliberate omission, misrepresentation or falsification of any information contained in the Provider

Enrollment Application, this AGREEMENT (if applicable) and Disclosure Statement or contained in any communication supplying information to the DEPARTMENT may be punishable to the full extent allowed under the law, including but not limited to, revocation of this PROVIDER AGREEMENT, recovery of payments made, and assessment of civil monetary penalties.

16. Breach.

In addition to any breaches specified in other sections of this AGREEMENT, the failure of the PROVIDER to perform any of its obligations hereunder in whole or in part or in a timely or satisfactory manner constitutes a breach. A breach in this AGREEMENT may result in termination, suspension or recoupment of any or all PROVIDER payments and/or assessment of civil monetary penalties.

17. Duration and Termination of Agreement.

17.1 PROVIDER acknowledges this AGREEMENT shall be effective from the date the applicant is enrolled as a PROVIDER or from the date the PROVIDER is approved for continued enrollment and will remain in effect until terminated in writing.

17.2 This AGREEMENT may be terminated by either party, without cause, by giving twenty-eight (28) days notice in writing to the other party except as otherwise provided in this AGREEMENT.

17.2.1 DEPARTMENT's sole obligation, in the event of termination, shall be to pay for SERVICES provided prior to the effective date of the termination that are eligible for reimbursement.

17.3 DEPARTMENT may at its discretion, terminate this AGREEMENT in writing in the event the PROVIDER has failed to submit a claim for reimbursement to Medicaid or its agent within a twenty-four (24) month period.

17.4 DEPARTMENT may terminate this AGREEMENT if judicial interpretation of federal or state laws, regulations, or rules renders fulfillment of this AGREEMENT infeasible or impossible.

17.5 DEPARTMENT shall immediately terminate this AGREEMENT if the PROVIDER's license or certification, required by law or rule, is revoked, not renewed or is otherwise not in effect at the time SERVICE is provided.

17.6 DEPARTMENT may, at its discretion terminate this AGREEMENT if it determines the PROVIDER did not fully and accurately make any disclosure, including but not limited to board actions, or if the PROVIDER failed to notify the DEPARTMENT of any change as specified in "6. Provider Enrollment Process" of this AGREEMENT. All correspondence sent to the mailing or electronic address on file with the DEPARTMENT's fiscal agent shall be deemed to have been received by the PROVIDER.

17.7 DEPARTMENT may, at its discretion, terminate this AGREEMENT in writing when the PROVIDER fails to comply with any applicable regulations, statutes, administrative code, guidance, policy or provision of this AGREEMENT, either immediately or upon such notice as the DEPARTMENT deems appropriate in accordance with IDAPA 16.03.09.205, "Medicaid Basic Plan Benefits" or IDAPA 16.05.07.230, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct."

17.8. PROVIDER understands and agrees its conduct may be subject to additional penalties or sanctions under Idaho Code §§ 56-209h, 56-227, 56-227A, 56-227B, and 56-227E, as amended, IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse and Misconduct", and 42 CFR Part 438 Managed Care, as applicable and amended. PROVIDER also understands there are federal penalties for false reporting and

fraudulent acts committed during the course and scope of this AGREEMENT. Notice of these sanctions shall in no way imply they represent an exclusive or exhaustive list of available actions concerning fraud and abuse.

18. Additional terms.
PROVIDER agrees to abide by any applicable terms if any, as attached and/or any applicable provisions of 42 CFR Part 438 Managed Care, as amended.

19. Construction, Severability, and Venue.
This AGREEMENT shall be governed, construed, and enforced in accordance with the laws and regulations of the state of Idaho and appropriate federal statutes and regulations. The provisions of this AGREEMENT are severable and independent, and if any such provision shall be determined to be unenforceable, in whole or in part, the remaining provisions and any partially enforceable provision shall, to the extent enforceable in any jurisdiction, nevertheless, be binding and enforceable. Any action to enforce the provisions of this AGREEMENT shall be brought in State District Court in Ada County, Boise, Idaho.

20. Interpretation.
In the event of inconsistency or ambiguity between the provisions of IDAPA and this AGREEMENT, the provisions of IDAPA shall be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, in which case such federal or state law shall be determinative of the obligations of the parties. In the event IDAPA is silent with respect to any ambiguity or inconsistency, the AGREEMENT (including Appendices) shall be determinative of the obligations of the parties. In the event that a dispute arises which is not addressed in any of the aforementioned documents, the parties agree to make every reasonable effort to resolve the dispute, in keeping with the objectives of the AGREEMENT and the budgetary and statutory constraints of the DEPARTMENT.

21. Headings. The headings in this AGREEMENT have been inserted for convenient reference only and shall not be considered in any questions of interpretation or construction of this AGREEMENT.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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ALEX J. ADAMS – Director

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November 13, 2024

MEDICAID INFORMATION RELEASE MA24-27

To: All Managed Care and ORP Providers

From: Juliet Charron, Deputy Director

Subject: Update to the Ordering, Referring and Prescribing Provider Agreement

Idaho Medicaid is updating the terms of the Medicaid Provider Agreement (attached). Per the terms of the Medicaid Provider Agreement, section 1. Compliance:

> *"The DEPARTMENT reserves the right to amend this AGREEMENT by providing the PROVIDER twenty-eight (28) day notice, as published within an Information Release (IR), and PROVIDER is deemed to accept, following such notice period. This AGREEMENT will be deemed modified, revised, or terminated to comply with any change on the effective date of such change."*

This updated agreement primarily changes language around the provision of insurance information in section 7.4. Professionalism.

> *PROVIDER attests compliance with all requirements to maintain appropriate insurance coverage as applicable within the scope of their professional license/certification and services rendered.*

This version will apply to ordering, referring and prescribing providers including providers who contract with an Idaho Medicaid managed care contractor. The updated Medicaid Provider Agreement will be effective December 1, 2024. Providers enrolling to provide services for fee-for-service Medicaid **and** managed care organizations should review Information Release MA24-26 Base Medicaid Provider Agreement Update.

Idaho Medicaid will be implementing a phased roll-out for the required enrollment of managed care providers at a later time. Idaho Medicaid will notify providers at least sixty (60) days prior to this requirement being effective. We will do everything we can to provide timely and comprehensive information, reduce confusion, and minimize administrative burden as much as possible.

Specific questions not answered by the materials referenced above can be directed to MCPT@dhw.idaho.gov.

JC/wd

The content of this guidance document is not new law but is an interpretation of existing law prepared by the Idaho Department of Health and Welfare to supply clarity to the public about existing requirements under the law. This document does not bind the public, except as authorized by law or as incorporated into a contract. For additional information or to provide input on this document, contact the Division of Medicaid by emailing MCPT@dhw.idaho.gov or by calling 888-528-5861.

TERMS AND CONDITIONS

1. Compliance.

This Provider Agreement ("AGREEMENT") is entered into by and between the Department of Health and Welfare ("DEPARTMENT"), as the State of Idaho's administering agency with authority under Idaho Code, Title 56, Chapter 2, to enter into agreements with individuals or entities that are enrolled with a managed care organization, or are ordering, referring or prescribing referred to as "PROVIDER". This AGREEMENT is entered into for the purpose of defining the DEPARTMENT's expectations of providers who provide healthcare services, equipment, supplies or items and hereinafter referenced as "SERVICES" as a provider enrolled with a managed care organization hereinafter referenced as "NETWORK PROVIDER" to persons eligible for medical assistance and who submit claims for reimbursement in accordance with all applicable provisions of Idaho Statute, administrative code and federal regulations under the Medical Assistance Program ("MEDICAID") ; or who order, prescribe or refer for SERVICES. This AGREEMENT and the terms herein are conditions of payment as used in Section 56-§209h (5) of Idaho Code for NETWORK PROVIDERs. Failure to comply with any of the Terms and Conditions, or applicable ADDENDUMS incorporated herein, may affect PROVIDER's ability to continue participation in MEDICAID or may result in recovery of any payments made by the DEPARTMENT to the PROVIDER, assessment of civil monetary penalties, suspension of payments and/or exclusion from the Medicaid program.

This AGREEMENT and any applicable ADDENDUMS attached hereto and hereby incorporated by reference; are subject to modification, revisions, or termination in accordance with changes in federal or state laws, administrative code or regulations. The DEPARTMENT reserves the right to amend this AGREEMENT by providing the PROVIDER twenty-eight (28) day notice, as published within an Information Release (IR), and PROVIDER is deemed to accept, following such notice period. This AGREEMENT will be deemed modified, revised, or terminated to comply with any change on the effective date of such change.

This AGREEMENT delineates the responsibilities of the PROVIDER and any subcontractor, agent or employee of the PROVIDER, in regard to the MEDICAID Program. The PROVIDER certifies and agrees to the Terms and Conditions set forth below.

2. Regulations, Rules, Policies and Procedures.

2.1 The PROVIDER certifies that SERVICES provided will be provided to participants without regard to health status or need for healthcare services and will be provided without regard to race, color, age, sex, disability, or national origin in accordance with 45 CFR Part 90, Part 91 and Part 92 and 42 CFR Part 438, as applicable and as amended.

2.2 PROVIDER shall comply with all applicable provisions of 45 CFR Part 88, consistent with applicable court orders or as amended; the Health Insurance Portability and Accountability Act (HIPAA); Sections 262 and 264 of Public Law 104 -191, 42 USC Section 1320d, and applicable federal regulations at 45 CFR Subchapter C specific to Administrative Data Standards and 45 CFR Subchapter D - Health Information Technology and Related Requirements;170.215. PROVIDER shall additionally be responsible for protecting the confidentiality of participant information that is collected, used, or maintained according to IDAPA 16.05.01, "Use and Disclosure of Department Records," and 42 CFR § 431. Subpart F specific to unauthorized disclosure of applicant and beneficiary information.

2.3 The NETWORK PROVIDER shall comply with 42 USC §1396A(a)(68) and 42 CFR §438.600(a)(6,) as amended and applicable, if PROVIDER receives or makes annual payments of MEDICAID funds of at least five million dollars ($5,000,000).

2.4 The NETWORK PROVIDER shall ensure any individual providing interpretive SERVICES related to the provision of a health-related service, is a minimum of eighteen (18) years of age and meets the definition of qualified interpreter consistent with 28 CFR § 35.104.

2.5 Pursuant to 42 CFR § 431.107, the NETWORK PROVIDER acknowledges their compliance with all requirements specific to AGREEMENTS, as applicable and amended, and Advance Directives, as applicable and specified in 42 CFR Part 489, Subpart I and 42 CFR §417.436(d), as amended. Ordering, referring and prescribing PROVIDERs acknowledge their compliance with all requirements specific to AGREEMENTS, as applicable, and specified in 42 CFR Part 489.

2.6 PROVIDER acknowledges the responsibility to comply with all applicable parts of the False Claims Act (31 USC §§3729-3733) and 42 CFR §438.608(a)(6) as amended, including, but not limited to, educating employees about federal and State laws pertaining to civil or criminal penalties for false claims, false statements and whistleblower protections under such laws.

2.7 Pursuant to federal regulations at 42 CFR §455.105, PROVIDER shall if requested, furnish to the DEPARTMENT and/or the U.S. Department of Health and Human Services, within thirty-five (35) days of the date of the transaction or the date of the written request, full and complete information related to certain business transactions, specifically:

2.7.1 ownership of any subcontractor with whom the PROVIDER has had business transactions totaling more than $25,000 during the twelve (12) month period preceding the most recent business transaction or ending on the date of the request, as applicable; and

2.7.2 pursuant to 42 CFR Part 455, Subpart B, any significant business transaction, between the PROVIDER and any wholly owned supplier, or between the PROVIDER and any subcontractor, during the 5-year period preceding the most recent business transaction or ending on the date of the request.

2.8 PROVIDER certifies that SERVICES provided to participant are not in violation of Idaho Code § 18-8901.

3. Administrative Code.

PROVIDER shall comply with all applicable provisions of the Idaho Administrative Code, as amended, including but not limited to: IDAPA 16.03.01 - "Eligibility for Health Care Assistance for Families and Children", IDAPA 16.03.05 – "Eligibility for Aid to the Aged, Blind, and Disabled", IDAPA 16.03.09 – "Medicaid Basic Plan Benefits", IDAPA 16.03.10 – "Medicaid Enhanced Plan Benefits", IDAPA, 16.03.13 – "Consumer Directed Services", IDAPA 16.03.17 – "Medicare/Medicaid Coordinated Plan Benefits", and IDAPA 16.03.18 – "Medicaid Cost Sharing", IDAPA – 16.05.03 "Contested Case Proceedings and Declaratory Rulings", IDAPA 16.05.06 "Criminal History and Background Checks", and IDAPA 16.05.07 – "The Investigation and Enforcement of Fraud, Abuse and Misconduct."

4. Policy Guidance.

NETWORK PROVIDERS participating in a managed care program must adhere to applicable policies and communications by the managed care program.

5. Employee Training.

NETWORK PROVIDER acknowledges responsibility to ensure employees, subcontractors and agents of the PROVIDER receive training specific to the usage and adherence of all applicable provisions of policy within this AGREEMENT for PROVIDERS providing services in any delivery system and by any mode including but not limited to, all applicable IDAPA rules, policy documents and guidance, and managed care program contracts as amended and applicable.

6. Provider Enrollment Process.

6.1 PROVIDER shall comply with the DEPARTMENT's enrollment processes and acknowledges the DEPARTMENT's authority to make provider enrollment decisions, which may include but is not limited to, mandatory denial of a Provider Agreement in accordance with IDAPA 16.03.09.200.06. PROVIDER acknowledges and agrees PROVIDER and its principals will be held responsible for violations of this AGREEMENT through any acts or omissions by the PROVIDER, its employees, its subcontractors or its agents specific to the provider enrollment process, including but not limited to, failure to disclose the revocation, termination or voluntary termination of an enrollment or if any party specified within 42 CFR § 455.106(c) has been convicted of a criminal offense.

6.1.1 PROVIDER understands this includes all applicable disclosures provided within 42 CFR §422.104 applicable to relationships between those who have an ownership interest, a control interest operational or managerial control of the PROVIDER organization as applicable.

6.1.2 Pursuant to federal regulations at 42 CFR Part 455, Subpart B, "Disclosure of Information by Providers and Fiscal Agents" and by reference 42 CFR §438.602(c) as applicable PROVIDER shall comply with the disclosure of ownership requirements; and agrees that for the purposes of this AGREEMENT, principal of the PROVIDER includes all agents, corporate officers, directors, partners of any partnership entity, including a professional corporation, association, limited liability company, those participating through a managed care program or their fiscal agent with either indirect ownership or control interest.

6.1.3 NETWORK PROVIDER understands they may make agreements to provide SERVICES through a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP) and acknowledge their responsibility under such agreements to comply with all applicable parts of 42 CFR Part 438, as amended in addition to all applicable provisions of this AGREEMENT.

6.1.3.1 NETWORK PROVIDER further acknowledges this AGREEMENT must be approved within one hundred twenty (120) days if applicable, for enrollment or credentialing with an MCO, PIHP or PAHP, in accordance with 42 CFR §438.602.

6.1.3.2 NETWORK PROVIDER understands that if rendering services only under an agreement with an MCO, PIHP or PAHP, PROVIDER is not required to render services to participants in the FFS network as provided by 42 CFR §438.608(b).

6.2 PROVIDER acknowledges this AGREEMENT is not transferable or assignable. PROVIDER also acknowledges that at any time during the course of this AGREEMENT, PROVIDER shall notify the DEPARTMENT of any change in information contained in this AGREEMENT or their Provider Enrollment application, including within thirty-five (35) days after the change. Changes PROVIDERs are required to report include, but are not limited to, changes (or impending changes) in ownership or control information described in 42 CFR 455 Subpart B; indirect ownership, service locations, changes to licensure, tax information, bankruptcy; physical, mailing or electronic addresses, phone number; or the addition or removal of Licensed Medical Service

Providers. Change in ownership or control information requires full disclosure of the terms of the sale agreement, submittal of a new enrollment application and execution of a new AGREEMENT.

7. **Professionalism.**

7.1 PROVIDER shall provide SERVICES in accordance with all applicable requirements within, Idaho state statutes, Idaho Administrative Code And 42 CFR Part 438 Managed Care.

7.2 PROVIDER shall obtain and maintain licenses, permits, certification, registration and authority necessary to conduct business and provide service under this AGREEMENT and 42 CFR Part 438 Managed Care, as applicable. Copies of these must be submitted to Gainwell's Provider Enrollment when requested.

7.3 PROVIDER shall comply with all applicable state and federal laws.

7.4 PROVIDER attests compliance with all requirements to maintain appropriate insurance coverage as applicable within the scope of their professional license/certification and services rendered.

7.5 PROVIDER agrees to uphold professionally recognized community standards of care and if applicable, retain non-Physician practitioners or paraprofessionals who have appropriate qualifications, licensing or certification as specified by the DEPARTMENT or a contract under 42 CFR Part 438 Managed Care. PROVIDER additionally agrees to provide appropriate supervision of such individuals.

7.6 PROVIDERs shall verify and ensure all employees, subcontractors and agents meet the fingerprint-based Criminal History Background Check provisions, as required by the DEPARTMENT under IDAPA 16.05.06, "Criminal History and Background Checks" and IDAPA 16.03.09, "Medicaid Basic Plan Benefits".

7.7 PROVIDER shall abide by all applicable laws regarding the Medicaid participant's right to privacy, dignity, and free choice of providers and agrees to comply with 42 CFR, Chapter I, Subchapter A, Part 2 specific to Confidentiality of Substance Use Disorder Patient Records and 45 CFR, §164.524, as amended to afford access to records for SERVICES.

7.8 PROVIDER shall abide by this AGREEMENT and any applicable Addendums or supplemental agreements, as amended.

8. **Records Management.**

8.1 The NETWORK PROVIDER agrees to legibly document all SERVICES in accordance with professionally recognized standards to support each claim for reimbursement by MEDICAID or its agent, at the time it is provided, in compliance with the requirements specified in the Idaho Medicaid Provider Handbook (Provider Manual), Idaho Code, §56-209h(3), applicable DEPARTMENT rules and this AGREEMENT, as amended. Such documentation shall be maintained for at least five years after the date of service, in accordance with IDAPA 16.05.07.101 or as required by other DEPARTMENT rule. Failure to comply with documentation requirements may result in the recoupment of Medicaid payments.

8.2 The NETWORK PROVIDER shall ensure their cooperation with the DEPARTMENT's Medicaid Program Integrity Unit (MPIU), the Attorney General's Medicaid Fraud Control Unit and the U.S. Department of Health and Human Services, or their agents by providing immediate access in accordance with Idaho Code §56-209h and IDAPA 16.05.07 "The Investigation and Enforcement of Fraud, Abuse and Misconduct" to all records, documents, material, and data in any medium which supports SERVICES billed to MEDICAID or its designee, at the time the request is made.

8.2.1 The NETWORK PROVIDER also agrees to comply with applicable Quality Assurance audits specific to IDAPA 16.03.10, and as provided by any ADDENDUM to this AGREEMENT or agreement in a managed care program.

9. Accurate Billing.

9.1 The NETWORK PROVIDER shall certify by their signature or through their designee, including electronic signatures on a claim form or transmittal document, that the SERVICES claimed were actually provided in accordance with professionally recognized standards of health care, their contract with a Managed Care Organization and any policies they may have, all applicable DEPARTMENT rules, and this AGREEMENT.

9.2 The NETWORK PROVIDER agrees to be responsible for the accuracy of claims submitted to the DEPARTMENT or its agent whether submitted on paper, electronically or through a billing service.

9.3 The NETWORK PROVIDER ensures SERVICES are claimed only under one program and one provider type regardless of the delivery system or mode of delivery and to immediately repay the DEPARTMENT or its designee for any SERVICE the DEPARTMENT or the PROVIDER determines were not properly provided, properly documented, or properly claimed.

9.4 Pursuant to 42 USC §1320a-7 and 42 USC §1320c-5, the NETWORK PROVIDER shall bill MEDICAID or its agent only for SERVICES delivered by individuals not excluded from MEDICAID; and additionally, assures all payments are correctly applied to participant accounts and credited timely.

10. Secondary Payor or Third-Party Liability.

10.1 The NETWORK PROVIDER agrees to seek payment first from all other applicable sources of payment prior to submitting a claim for SERVICES to MEDICAID or its agent specific to 42 CFR §433 - Subpart D. for third party liability. Additionally, PROVIDER acknowledges MEDICAID as the payer of last resort and agrees to comply with 42 CFR §447.20(b).

10.1.1 As an exception to 10.1, Indian Health Services (IHS), purchased or referred care healthcare (PRC) by IHS, and health insurance plans self-funded by a federally recognized tribe are secondary to MEDICAID according to 42 CFR §136.203.

10.2 The NETWORK PROVIDER acknowledges that if a secondary payor or third party pays the participant for the SERVICES provided, the PROVIDER may bill the participant for that amount if written notice of financial responsibility was provided in accordance with MEDICAID policy and prior to the delivery of the service; and

10.3 The NETWORK PROVIDER acknowledges they cannot refuse to furnish SERVICES to a participant if a third-party is potentially liable for the service.

10.4 The NETWORK PROVIDER agrees to not bill the DEPARTMENT or its agent if a secondary payor or third-party payment is made to the PROVIDER, unless the secondary payor or third-party payment is less than the amount paid by MEDICAID or its agent.

11. Reimbursement.

11.1 The NETWORK PROVIDER understands they are to complete the appropriate claim form and acknowledges responsibility for the validity and accuracy of claims whether submitted on paper, electronically or through a billing service to MEDICAID or the DEPARTMENT's agent for reimbursement.

11.2 The NETWORK PROVIDER agrees to submit a request for prior authorization, if one is required, and to receive an approval for that request, prior to providing the requested SERVICES to the participant except where allowed by MEDICAID or its agent.

11.3 The NETWORK PROVIDER understands that reimbursement for the SERVICES by MEDICAID or its agent is contingent on the PROVIDER being correctly enrolled, licensed and credentialed, if applicable; conducting a determination of medical necessity for the SERVICES that meets all DEPARTMENT requirements or its agent if applicable; eligibility of the participant for the SERVICES at the time it is rendered; coverage limitations at the time provided; timely submittal of prior authorization when applicable; and the PROVIDER billing per all applicable requirements, including but not limited to administrative code, policies and requirements specified by the National Correct Coding Initiative.

12. Payment in Full.

12.1 Pursuant to 42 CFR §447.15 the NETWORK PROVIDER agrees to accept MEDICAID payment or payment by its agent, as payment in full, for any SERVICES.

12.1.1 The NETWORK PROVIDER also agrees that prior to delivering a non-covered or excluded MEDICAID SERVICES to a participant, PROVIDER will supply an itemized written notice to the participant, which informs them of their responsibility to pay for the SERVICES they are receiving, prior to rendering the SERVICES and require the participant to affix their signature as acknowledgement of their financial responsibility. If the participant qualifies for a period of retroactive eligibility for Medicaid, this subsection does not apply during the retroactive period.

12.1.2 The NETWORK PROVIDER agrees to comply with the billing requirements specific to participant financial responsibility as provided within administrative code or by a managed care program, as applicable.

13. Officers and Employees of the State.

PROVIDER acknowledges that no official, employee, or agent of the DEPARTMENT shall be in any way personally liable or responsible for any term of this AGREEMENT, whether express or implied, nor for any statement, representation, or warranty made in connection with this AGREEMENT. A guarantee of payment for SERVICES cannot be made by an official, employee or agent of the DEPARTMENT.

14. Provider Liability.

PROVIDER agrees if their organization is any type of business entity, the entity and all general or limited partnership interests and all shareholders, with a direct or indirect ownership or control interest, regardless of the percentage of ownership, are jointly and severally liable for any breach of this AGREEMENT, and that action by the DEPARTMENT against the PROVIDER may result in action against any or all such individuals in the entity.

15. Provider Revalidation.

15.1 PROVIDER acknowledges that the DEPARTMENT requires all enrolled providers to revalidate enrollment information at least every five years, in accordance with 42 CFR §455.414 and 42 CFR §438.602(b) if applicable. PROVIDER also acknowledges the DEPARTMENT may conduct off-cycle revalidations for certain program integrity purposes as allowed by 42 CFR §455.452 to ensure compliance with these requirements. Upon the DEPARTMENT's request to revalidate its enrollment, the PROVIDER has ninety (90) days from the postmark on the Revalidation Notice to submit the completed enrollment to the DEPARTMENT for approval.

15.2 PROVIDER also acknowledges all information disclosed by the PROVIDER is subject to verification. Any deliberate omission, misrepresentation or falsification of any information contained in the Provider

Enrollment Application, this AGREEMENT (if applicable) and Disclosure Statement or contained in any communication supplying information to the DEPARTMENT may be punishable to the full extent allowed under the law, including but not limited to, revocation of this PROVIDER AGREEMENT, recovery of payments made, and assessment of civil monetary penalties.

16. Breach.

In addition to any breaches specified in other sections of this AGREEMENT, the failure of the PROVIDER to perform any of its obligations hereunder in whole or in part or in a timely or satisfactory manner constitutes a breach. A breach in this AGREEMENT may result in termination, suspension or recoupment of any or all PROVIDER payments and/or assessment of civil monetary penalties.

17. Duration and Termination of Agreement.

17.1 PROVIDER acknowledges this AGREEMENT shall be effective from the date the applicant is enrolled as a PROVIDER or from the date the PROVIDER is approved for continued enrollment and will remain in effect until terminated in writing.

17.2 This AGREEMENT may be terminated by either party, without cause, by giving twenty-eight (28) days notice in writing to the other party except as otherwise provided in this AGREEMENT.

17.2.1 DEPARTMENT's sole obligation, in the event of termination, shall be to pay for SERVICES provided prior to the effective date of the termination that are eligible for reimbursement.

17.3 DEPARTMENT may terminate this AGREEMENT if judicial interpretation of federal or state laws, regulations, or rules renders fulfillment of this AGREEMENT infeasible or impossible.

17.4 DEPARTMENT shall immediately terminate this AGREEMENT if the PROVIDER's license or certification, required by law or rule, is revoked, not renewed or is otherwise not in effect at the time SERVICE is provided.

17.5 DEPARTMENT may, at its discretion terminate this AGREEMENT if it determines the PROVIDER did not fully and accurately make any disclosure, including but not limited to board actions, or if the PROVIDER failed to notify the DEPARTMENT of any change as specified in "6. Provider Enrollment Process" of this AGREEMENT. All correspondence sent to the mailing or electronic address on file with the DEPARTMENT's fiscal agent shall be deemed to have been received by the PROVIDER.

17.6 DEPARTMENT may, at its discretion, terminate this AGREEMENT in writing when the PROVIDER fails to comply with any applicable regulations, statutes, administrative code, guidance, policy or provision of this AGREEMENT, either immediately or upon such notice as the DEPARTMENT deems appropriate in accordance with IDAPA 16.03.09.205, "Medicaid Basic Plan Benefits" or IDAPA 16.05.07.230, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct."

17.7. PROVIDER understands and agrees its conduct may be subject to additional penalties or sanctions under Idaho Code §§ 56-209h, 56-227, 56-227A, 56-227B, and 56-227E, as amended, IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse and Misconduct", and 42 CFR Part 438 Managed Care, as applicable and amended. PROVIDER also understands there are federal penalties for false reporting and fraudulent acts committed during the course and scope of this AGREEMENT. Notice of these sanctions shall in no way imply they represent an exclusive or exhaustive list of available actions concerning fraud and abuse.

18. Additional terms.

PROVIDER agrees to abide by any applicable terms if any, as attached and/or any applicable provisions of 42 CFR Part 438 Managed Care, as amended.

19. Construction, Severability, and Venue.
This AGREEMENT shall be governed, construed, and enforced in accordance with the laws and regulations of the state of Idaho and appropriate federal statutes and regulations. The provisions of this AGREEMENT are severable and independent, and if any such provision shall be determined to be unenforceable, in whole or in part, the remaining provisions and any partially enforceable provision shall, to the extent enforceable in any jurisdiction, nevertheless, be binding and enforceable. Any action to enforce the provisions of this AGREEMENT shall be brought in State District Court in Ada County, Boise, Idaho.

20. Interpretation.
In the event of inconsistency or ambiguity between the provisions of IDAPA and this AGREEMENT, the provisions of IDAPA shall be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, in which case such federal or state law shall be determinative of the obligations of the parties. In the event IDAPA is silent with respect to any ambiguity or inconsistency, the AGREEMENT (including Appendices) shall be determinative of the obligations of the parties. In the event that a dispute arises which is not addressed in any of the aforementioned documents, the parties agree to make every reasonable effort to resolve the dispute, in keeping with the objectives of the AGREEMENT and the budgetary and statutory constraints of the DEPARTMENT.

21. Headings. The headings in this AGREEMENT have been inserted for convenient reference only and shall not be considered in any questions of interpretation or construction of this AGREEMENT.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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ALEX J. ADAMS – Director

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November 6, 2024

MEDICAID INFORMATION RELEASE MA24-28

To: Personal Assistance Agencies

From: Juliet Charron, Deputy Director

Subject: Changes To The Family Personal Care Services (FPCS) Program

Due to concerning trends of suspected and confirmed fraud and abuse; significant program growth beyond budget projections; and insufficient staff resources to conduct appropriate oversight, DHW will be terminating the Family Personal Care Services effective January 31, 2025.

The Personal Care Services (PCS) benefit will continue to be available for both children and adults. Qualifying providers will revert to requirements in place prior to the pandemic and legally responsible individuals (parents and spouses) will no longer be able to provide PCS for their family members.

Background

During the public health emergency, CMS allowed a temporary flexibility to decrease the need for direct care workers in people's homes and therefore prevent the spread of COVID-19. The department implemented a temporary flexibility to allow legally responsible parents and spouses to be paid caregivers to their own loved ones who are Medicaid participants with disabilities. This is known as Family Personal Care Services (FPCS). Prior to this flexibility, legally responsible individuals were expressly prohibited in federal and state regulation from being paid personal care aides. Thus, this temporary allowance permitted parents and spouses to be employed by direct care staffing agencies and be paid to work in their homes caring for their loved ones.

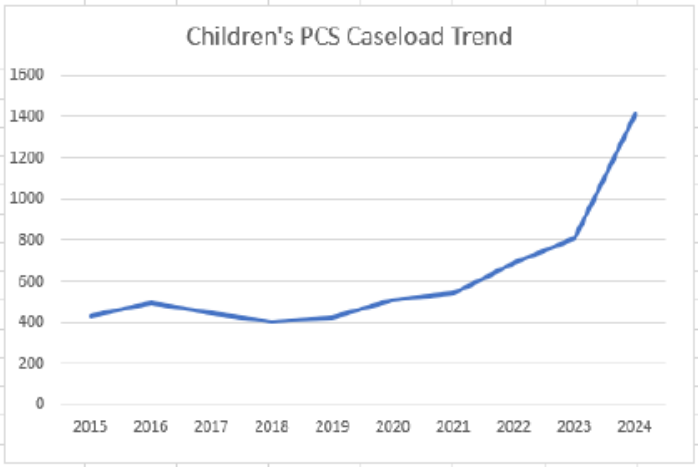
The department extended this flexibility through March 21, 2025, with limited parameters given current staff capacity to oversee the program.

Status

The department has insufficient staff and funding to support this program and its exponential growth and ensure the program's operational integrity.

For many years, there were roughly 500 participants in in children's personal care and private duty nursing services. Enrollment jumped to 546 in 2021, and significantly increased in each subsequent year. We had 1,178 participants in the program in October 2024 and project enrollment at 1,413 by the end of this calendar year, a 75% increase in enrollment since 2023 when the public health emergency ended.

Year	Children's PCS Caseload Trend
2015	434
2016	493
2017	446
2018	402
2019	426
2020	507
2021	546
2022	688
2023	809
2024	1413
	*1,178 as of 10/29/24



This ongoing enrollment surge is due in part to program abuse. We have observed that some parents, spouses, and provider agencies are trading tips on how to seemingly exploit this program, such as:

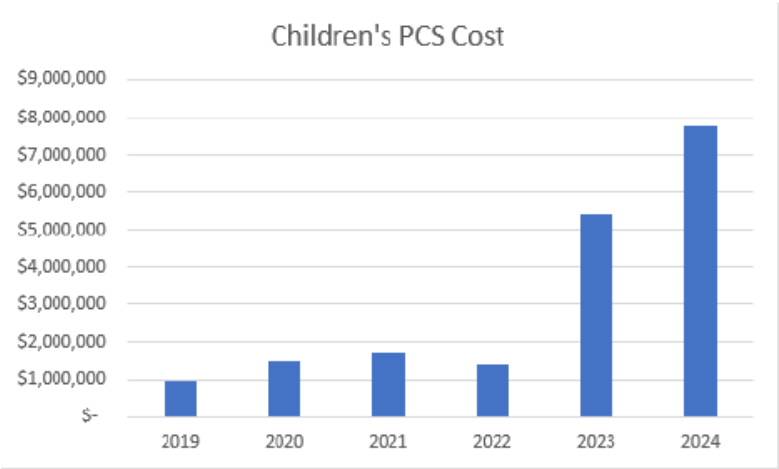
- Sharing information on how to manipulate and respond to the medical assessment in order to maximize authorized hours of service paid by Medicaid.
- Photocopying and sharing eligibility paperwork rather than obtaining independent confirmation from two direct care staffing agencies that they have insufficient staff to serve the child/spouse (as required by the program).
- Recruiting families outside Idaho to move to Idaho to be paid for these services.
- Advertising to employ parents to care for their child(ren) with special needs, saying there is, "No need to work away from home." This incentivizes parents who never previously had a need or interest in these services to apply.
- Communicating the starting pay rates for area provider agencies, resulting in participants switching agencies *not* due to a quality-of-care concern, but exclusively to maximize the household's income.

Other fraudulent and problematic activities include:

- Claiming to care for children but performing other activities at the same time (i.e., driving for Uber).
- Inappropriately double- and triple-billing by caring and billing for multiple children simultaneously (the program only allows a provider to care for one individual at a time). This also presents serious questions of quality and adequacy of care when the child has been identified to need a specific number of hours of care, but it is physically impossible for the parent to serve multiple children for those hours. This includes some parents logging more than 24 hours of care rendered in a day, as confirmed by electronic visit verification (EVV) data.
- Using Medicaid as supplemental household income by determining the needs of the child(ren) on the income received. To quote one mother, "I want PCS for four of my kids. When I find out what my income will be, I might get PCS for [the others]."
- Repeatedly calling department staff to inquire about the status of assessments and actively encouraging others to do the same, taking time away from employees actually completing those assessments and other work for the other Medicaid participants.
- Households that have had continuous Medicaid coverage in the past, but never requested or identified a need for a child (or children) in the household to receive PCS until this flexibility was implemented, with no discernible change in the child's condition that would warrant such a request.
- Instances in which one individual is clocking in and out of services for multiple participants in multiple households that appear to be efforts to avoid detection by quality assurance monitoring of EVV data. In the last calendar quarter, one individual clocked in and out with overlapping visit segments (which is prohibited) for 21 FPCS participants.
- Households selectively providing service hours to attempt to control income that would affect eligibility for other public benefits, which suggests that the child did not medically require the total number of hours authorized.

Not only has enrollment increased, costs have nearly quadrupled since 2022 and are not sustainable within the current appropriation if the program growth continues.[1] We are nearing $8,000,000 spent so far in 2024, with one full quarter remaining in the calendar year. By comparison, the FY 2025 budget authorized by the legislature included just $4,200,000 in anticipated expenditures for FPCS, a difference of 90%.

[1] Medicaid rates changed in summer 2024. The historical costs have been adjusted to account for the change in reimbursement rates.



While expenditures are based on authorized hours of services that are approved by clinical staff, we are aware of many inappropriate attempts to increase the number of authorized hours by families. Further, as described above, the department is aware of significant fraud, waste, and abuse and identified health and safety concerns for participants identified with this program since the benefit was made permanent in late 2023. As stewards of taxpayer dollars and in our role in overseeing this entitlement program serving vulnerable children and adults, we cannot continue to operate a program with such high rates of suspected and known fraud, waste, and abuse potential health and safety issues for participants.

Many of these cases have come to our attention through complaints or observed and experienced interactions with families, content posted on social media, referrals from other state agencies that serve the same population, and referrals by word of mouth from community partners and individual community members. While several of these examples and cases have been referred to the Medicaid Program Integrity Unit, we do not have the infrastructure to administratively identify all cases warranting additional inquiry and pursuit of recovery. Moreover, if fraud is being perpetrated by the household/family, any recovery of funds would be from the agency that the parent/spouse is technically employed by, therein weakening Idaho's already tenuous network of direct care agencies.

The Department recognizes that there are still many families who use this benefit and program appropriately, legitimately need support, and cannot find direct care workers to provide services to their children. The Department has actively engaged in marketing and outreach activities to bolster the direct care workforce in Idaho over the last two years and has observed an approximately 10% growth in the number of unduplicated direct care workers, not including parents and spouses, as identified in the state's Electronic Visit Verification data. The Department will share options through external communications to agencies and families during this transition. Department staff are always available to families and provider agencies to discuss options.

The Bureau of Long Term Care team responsible for administration and oversight of the FPCS program will be implementing additional safeguards and operational processes to provide as much oversight as we are able to during the remaining months of the FPCS flexibility. These activities will include:

- Quarterly supervisory oversight forms submitted by provider agencies will require a narrative to validate that each visit did, in fact, occur and is reflective of adequate clinical oversight.
- Functional assessments for whom the primary respondent is also the direct care worker (including parents and spouses) will be subject to post-processing internal review by the Medical Director to validate that PCS are medically necessary. Additional medical documentation to substantiate the participant's ongoing need for services may be requested.

Processing timeframes for new requests will be moved to 30 days. The team is unable to maintain the current 14-day timeline without detrimental impact to other programs and services administered by these staff. In addition, the Medicaid Program Integrity Unit is actively pursuing recoupments and assessing penalties as appropriate and will refer all credible allegations of fraud to the Medicaid Fraud and Control Unit in the Office of the Attorney General.

Next Steps

CMS has advised the Department that an amendment to the authority currently invoked for this flexibility is necessary to carry out early termination of the program. Early termination will allow the Department to pause enrolling new applicants, and therefore ensure the Legislature has maximum flexibility to determine the appropriate path forward.

The Department will post the draft amendment on Townhall Idaho and send a letter to Idaho Tribes as required. The Department will accept comments for thirty (30) calendar days and send the submission to CMS in early December with a requested effective date of January 31, 2025.

It is our hope that program advocates and participants can work with the Legislature to determine which safeguards are appropriate to resolve the troubling issues we are seeing on the ground, recognizing the need for additional staff capacity if labor-intensive safeguards are selected.

We look forward to working collaboratively with provider agencies, parents and spouses of participants needing personal care services, and other stakeholders to design and implement a sustainable program with integrity deserving of Idahoans' support.

JC

The content of this guidance document is not new law but is an interpretation of existing law prepared by the Idaho Department of Health and Welfare to supply clarity to the public about existing requirements under the law. This document does not bind the public, except as authorized by law or as incorporated into a contract. For additional information or to provide input on this document, contact the Division of Medicaid by emailing MCPT@dhw.idaho.gov or by calling 888-528-5861

Provider Training Opportunities

You are invited to attend the following webinars offered by Gainwell Technologies Regional Provider Relations Consultants.

December: Respite Care
This training will walk Respite Care providers through the process of signing up for a trading partner account, viewing prior authorizations, creating patient rosters, verifying eligibility, accessing remittance advice reports, and submitting and reviewing claims.

Training is delivered at the times shown in the table below. Each session is open to any region, but space is limited to 25 participants per session, so please choose the session that works best for your schedule. To register for training, or to learn how to register, visit www.idmedicaid.com.

	December	January	February
	Respite Care	**Eligibility**	**COB**
10-11:00 AM MT	12/18/2024	1/15/2025	2/18/2025
	12/19/2024	1/16/2025	2/19/2025
	12/17/2024	1/21/2025	2/20/2025
2-3:00 PM MT	12/11/2024	1/08/2025	2/12/2025
	12/12/2024	1/09/2025	2/13/2025
	12/19/2024	1/21/2025	2/18/2025
	12/17/2024	1/23/2025	2/20/2025

If you would prefer one-on-one training in your office with your Regional Provider Relations Consultant, please feel free to contact them directly. Contact information for Provider Relations Consultants can be found on page 33 of this newsletter.

DHW Resource and Contact Information

DHW Website	https://healthandwelfare.idaho.gov/
Idaho CareLine	2-1-1 1 (800) 926-2588
Medicaid Program Integrity Unit	P.O. Box 83720 Boise, ID 83720-0036 prvfraud@dhw.idaho.gov Hotline: 1 (208) 334-5754 Fax: 1 (208) 334-2026
Telligen	1 (866) 538-9510 Fax: 1 (866) 539-0365 http://IDMedicaid.Telligen.com
Healthy Connections Regional Contact Numbers	
Region I **Coeur d'Alene**	1 (208) 666-6766 1 (800) 299-6766
Region II **Lewiston**	1 (208) 799-5088 1 (800) 799-5088
Region III **Caldwell**	1 (208)-334-4676 1 (800) 494-4133
Region IV **Boise**	1 (208) 334-4676 1 (800) 354-2574
Region V **Twin Falls**	1 (208) 736-4793 1 (800) 897-4929
Region VI **Pocatello**	1 (208) 235-2927 1 (800) 284-7857
Region VII **Idaho Falls**	1 (208) 528-5786 1 (800) 919-9945
In Spanish **(en Español)**	1 (800) 378-3385

Insurance Verification

HMS PO Box 2894 Boise, ID 83701	1 (800) 873-5875 1 (208) 375-1132 Fax: 1 (208) 375-1134

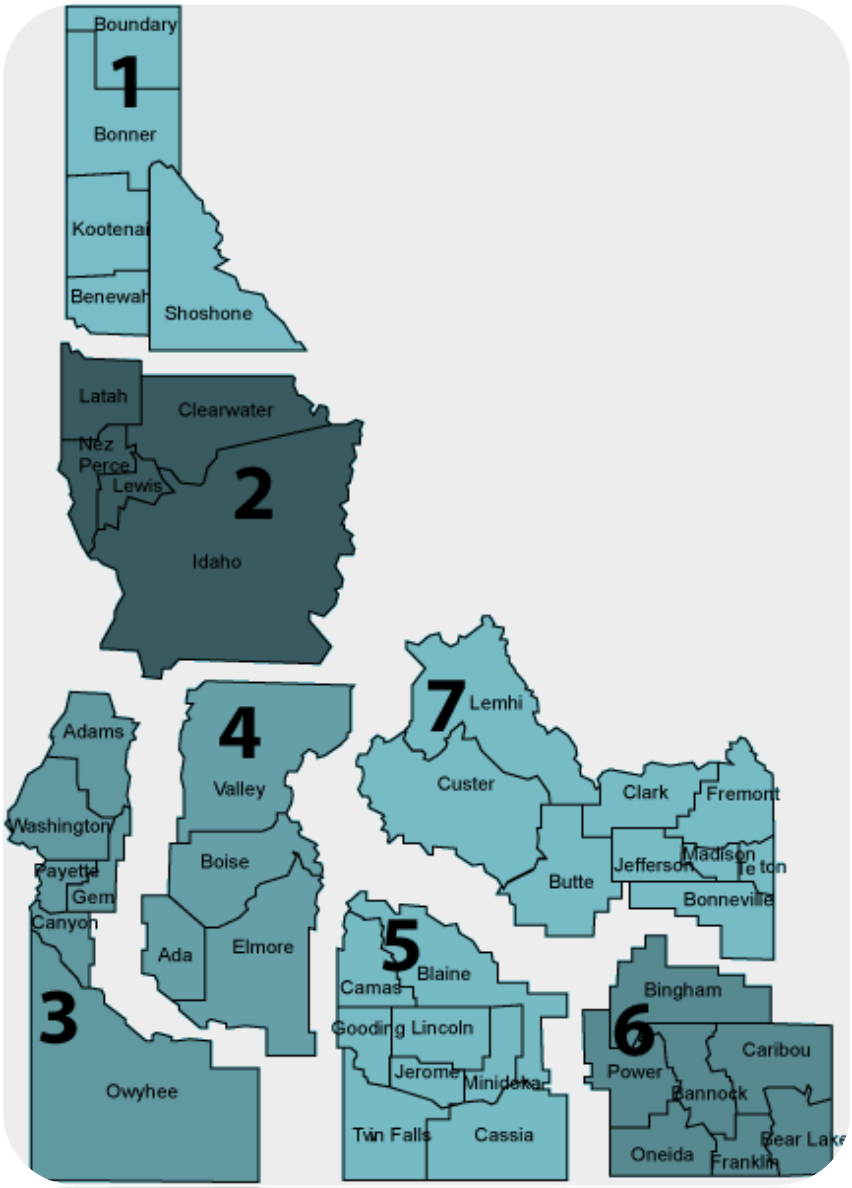
Gainwell Technologies Provider and Participant Services Contact Information

Provider Services	
MACS (Medicaid Automated Customer Service)	1 (866) 686-4272 1 (208) 373-1424
Provider Service Representatives Monday through Friday, 7 a.m. to 7 p.m. MT	1 (866) 686-4272 1 (208) 373-1424
E-mail	idproviderservices@gainwelltechnologies.com idproviderenrollment@gainwelltechnologies.com
Mail	P.O. Box 70082 Boise, ID 83707
Participant Services	
MACS (Medicaid Automated Customer Service)	1 (866) 686-4752 1 (208) 373-1432
Participant Service Representatives Monday through Friday, 7 a.m. to 7 p.m. MT	1 (866) 686-4752 1 (208) 373-1424
E-mail	idparticipantservices@gainwelltechnologies.com
Mail – Participant Correspondence	P.O. Box 70081 Boise, ID 83707
Medicaid Claims	
Utilization Management/Case Management	P.O. Box 70084 Boise, ID 83707
CMS 1500 Professional	P.O. Box 70084 Boise, ID 83707
UB-04 Institutional	P.O. Box 70084 Boise, ID 83707
UB-04 Institutional Crossover/CMS 1500/Third-Party Recovery (TPR)	P.O. Box 70084 Boise, ID 83707
Financial/ADA 2006 Dental	P.O. Box 70087 Boise, ID 83707

Gainwell Technologies Provider Services Fax Numbers

Provider Enrollment	1 (877) 517-2041
Provider and Participant Services	1 (877) 661-0974

Provider Relations Consultant (PRC) Information



Region 1 and the state of Washington
1 (208) 202-5735
Region.1@gainwelltechnologies.com

Region 2 and the state of Montana
1 (208) 202-5736
Region.2@gainwelltechnologies.com

Region 3 and the state of Oregon
1 (208) 202-5816
Region.3@gainwelltechnologies.com

Region 4
1 (208) 202-5843
Region.4@gainwelltechnologies.com

Region 5 and the state of Nevada
1 (208) 202-5963
Region.5@gainwelltechnologies.com

Region 6 and the state of Utah
1 (208) 593-7759
Region.6@gainwelltechnologies.com

Region 7 and the state of Wyoming
1 (208) 609-5062
Region.7@gainwelltechnologies.com

Region 9 all other states (not bordering Idaho)
1 (208) 609-5115
Region.9@gainwelltechnologies.com

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Boise, Idaho 83707

IDAHO DEPARTMENT OF HEALTH & WELFARE

Digital Edition

MedicAide is available online by the fifth of each month at www.idmedicaid.com. There may be occasional exceptions to the availability date as a result of special circumstances. The electronic edition reduces costs and provides links to important forms and websites.

***MedicAide* is the monthly informational newsletter for Idaho Medicaid providers.**
Editor: Shannon Tolman

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