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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 09-014-A

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid , CHIP, and Survey & Certification

Richard Armstrong, Director
Department of Health & Welfare
Towers Building – Tenth Floor
PO Box 83720
Boise, Idaho 83720-0036

MAY 1 1 2010

RE: Idaho SPA TN# 09-014A

Dear Mr. Armstrong,

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 09-014A. This amendment represents a complete rewrite of Attachment 4.19-D for nursing facilities (NFs), caps the NF per diem indirect care incentive payment at $9.50, and reduces the NF inflation index adjustment from two-percent to one-percent.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 09-014A is approved effective as of July 1, 2009. For your files, we are enclosing the HCFA-179 transmittal form and the amended plan pages.

If you have any questions concerning this state plan amendment, please contact Tom Couch, CMS' Boise Outstation Office, at 334-9482 or Thomas.Couch@cms.hhs.gov .

Sincerely,

[redacted]

Director
Center for Medicaid, CHIP, and Survey & Certification

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: 09-014-A (pt i)

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 1, 2009

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:
42 CFR 447.201

7. FEDERAL BUDGET IMPACT:
Total ($) Federal Funds
FFY 2009 ($689,000), FFY 2010 ($2,066,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, pgs. 1-27 (pt i)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, ~~with Appendices A-F~~, pgs. 1-27 (pt i)

10. SUBJECT OF AMENDMENT:
We are requesting this amendment to our State Plan to remove all outdated reimbursement methodologies, condense the existing reimbursement methodology explanation for nursing facilities and ~~ICF/MRs~~ to a high-level definition, and cite Idaho Code and Idaho Administrative Rules for further reimbursement methodology explanation. We changed reimbursement methodology to nursing facilities to establish a capped incentive payment rate of $9.50 per patient day and to reduce the inflation index adjustment to annual cost limits from 2% to 1%.

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:
Leslie M. Clement

14. TITLE:
Administrator

15. DATE SUBMITTED: 8/26/09

16. RETURN TO:
Leslie M. Clement, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0036

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: AUG 27 2009

18. DATE APPROVED: 5-11-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMCS

23. REMARKS:

2.22.10 - State authorized pen+ink changes.

FORM HCFA-179 (07-92)

STATE PLAN FOR MEDICAID PROVIDER REIMBURSEMENT
Long Term Care Services

Nursing facility (NF) and intermediate care services for the mentally retarded (ICF/MR) are paid for Medicaid recipients by means of rates determined in accordance with the following principles, methods and standards which comply with 1902(a)(13)(A), 1902(a)(13)(B), 1902(a)(13)(C), 1913(b), and 1902(a)(30) of the Social Security Act and Federal Regulations at 42 CFR 447 Subpart C, 42 CFR 447.250 through .252, .253, .255, .256, .257, .272, and .280. Rate setting principles and methods for Nursing Facility care and ICF/MR care is contained in Idaho Statute 56-101 through 56-135 effective 7/1/2009.

NURSING FACILITY

I. Introduction

01. Rate setting principles and methods for Nursing Facility care is contained in Idaho Administrative Code 16.03.10.257-258 (effective 7/1/09) and 16.03.10.235-256 and 259.296 (effective 3/19/07).

- Idaho's methodology is a cost-based prospective reimbursement system with an acuity adjustment for direct care costs. New rates are effective July 1st of each year and rebased annually.
- In no case will the rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is made as computed by the lower of costs or customary charges.
- Reimbursement rates will be set based on projected cost data from cost reports and audit reports.
- Reimbursement is to be set for freestanding and hospital-based facilities.
- Rate adjustments are made quarterly based on each facility's case mix index as of a certain date during the preceding quarter. Reference section II.01 on page 2 of Attachment 4.19-D.
- With the exception of the nursing facilities at Idaho state veterans homes, each skilled care facility's quarterly rate will be decreased two and seven-tenths percent (2.7%) from July 1, 2009, through June 30, 2010.

02. Data Sources used by the Department of Health and Welfare, Division of Medicaid are the following:

a. Year end reports which contain historical financial and statistical information submitted by the facility for past rate-setting years.
b. Utilization and payment history report.
c. Medicare Cost report.

II. Development of the Rate

01. **Applicable Case Mix Index (CMI).** The Medicaid CMI used in establishing each facility's rate is calculated based on the most recent assessment for each Medicaid resident in the nursing facility on the first day of the month of the preceding quarter (for example, assessments as of April 1are used to establish the CMI needed to establish rates for the quarter beginning July 1st). Facility-wide CMI is calculated based on the most recent assessment for all residents in the nursing facility. The CMI is recalculated quarterly and each nursing facility's rate is adjusted accordingly. A facility-wide CMI is also established each year by averaging four (4) calendar quarter CMIs for the cost reporting period from historical data to represent each fiscal quarter in the cost reporting period (e.g., for a provider with a September 30 year-end, the cost report year average will use the assessments from Jan. 1, Apr. 1, Jul. 1, and Oct. 1).

02. **Applicable Cost data**. The cost data used in establishing the cost components of the rate calculation are from the audited or unaudited cost report which ended during the previous calendar year (for example, cost reports ending during the period from January 1, 1998 - December 31, 1998 are used in setting rates effective July 1, 1999). The draft audit of a cost report submitted by a facility will be issued by the Department no later than five (5) months after the date all information required for completion of the audit is filed with the Department.

03. **Interim Rates**. Nursing facilities with unaudited cost reports are given an interim rate established by the Department until a rate is calculated based on an audited cost report. When audited data are available, a retroactive adjustment to the payment rate is made through the calculation of the finalized rate.

04. **Picture Date**. A point in time when case mix indexes are calculated for every nursing facility based on the most recent assessment for residents in the nursing facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the nursing facility's rate for the next quarter.

04. **Direct Care Cost Component.** The direct care cost component of a nursing facility's rate is determined as follows:

a. The direct care per diem cost limit applicable to the rate period for the two nursing facility categories: 1) free-standing and urban hospital-based nursing facilities, and 2) rural hospital-based nursing facilities is identified. The identified direct care cost limit is divided by the statewide average CMI for the cost reporting period, and then multiplied by the nursing facility's facility-wide CMI for the cost reporting period to derive the adjusted direct care per diem cost limit.

b. The adjusted direct care per diem cost limit is compared to the nursing facility's inflated direct care per diem costs. The lower of the two (2) amounts is then case mix adjusted.

i. If the adjusted direct care per diem cost limit is lower, the adjusted limit is divided by the nursing facility's facility-wide CMI for the cost reporting period, and then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period to arrive at the direct care cost component.

ii. If the inflated direct care per diem costs are lower, these costs, minus raw food and Medicaid related ancillary costs, are divided by the nursing facility's facility-wide CMI for the cost reporting period, then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period. Raw food and Medicaid related ancillary costs are then added back to arrive at the direct care cost component.

05. Indirect Care Cost Component. The indirect care cost component of a facility's rate is the lesser of the facility's inflated indirect care per diem costs or the indirect per diem cost limit for that type of provider -- free-standing and urban hospital-based nursing facilities, or rural hospital-based nursing facilities.

The following are indirect care costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM:

A. Activities
B. Administrative and general care costs
C. Dietary (non-"raw food" costs)
D. Employee benefits associated with the indirect salaries
E. Housekeeping
F. Laundry and linen
G. Medical records
H. Other costs not included in direct care costs, or costs exempt from cost limits
I. Plant operations and maintenance (excluding utilities)

The indirect cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with freestanding and hospital based nursing facilities included in the same array, and the bed-weighted median will be computed.

Increases or decreases in the direct and indirect cost limits will be determined by the limitations calculated in the most recent base year, indexed forward each year from the midpoint of the base year to the midpoint of the rate year by the inflation factor (provided by Global Insights Inc.,) plus one percent (1%) per annum. The calculated direct and indirect cost limits will not be allowed to decrease below the limitations effective in the base year. The following defines the first year (2000) Indirect Cost Component:
The indirect cost component rate calculation is based on a percentage above the median. Freestanding Skilled Nursing Facilities (SNFs), Urban Hospital-Based: Direct: 128% above the median; Indirect: 123.25% above the median. Rural Hospital-Based: Direct: 155% above the median; Indirect: 147.25% above the median.

The maximum rate of growth on the cost limits, and the minimum cost limitation, and the period of their use will be examined and agreed upon by the nursing facility oversight committee who consists of representatives from the Department, the state association(s) representing freestanding nursing facilities, and the state association(s) representing hospital-based nursing facilities. The caps will not increase faster than the rate of inflation, Global Insights inc., (successor of DRI), plus an economically feasible addition not to exceed 1%.

06. Efficiency Incentive. The efficiency incentive is available to those providers, both free-standing and hospital-based, which have inflated per diem indirect care costs less than the indirect per diem cost limit for that type of provider. The efficiency incentive is calculated by multiplying the difference between the per diem indirect cost limit and the facility's inflated per diem indirect care costs by fifty percent (50%) not to exceed $9.50 (nine dollars and fifty cents) per patient day. There is no incentive available to those facilities with per diem costs in excess of the indirect care cost limit, or to any facility based on the direct care cost component.

07. Costs Exempt from Limitation. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates. Nursing Facilities can have interim adjustments to rates as a result of new legal mandates arriving from Federal or State laws or rule changes. Certain costs may be excluded from the cost limit calculations, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective rates as provided in this Section to assure equitable reimbursement. Changes of more than fifty cents ($.50) per patient day in costs otherwise subject to the cost limitations incurred by a facility as a result of changes in state or federal laws or rules will be reported separately on the cost report until such time as they can be properly reflected in the cost limits. The provider will report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. These costs will be reported separately and will not be reimbursed through the rate setting process until the costs are fully represented in the cost data used to establish the cost limitations and rates. If more than one (1) increase occurs as a result of one (1) or more law or rule changes, the costs from each event are to be reported separately.

For interim rate purposes, the provider is granted an increase in its prospective rate to cover such cost increases. A cost statement covering a recent period is required with justification for the increased costs. The actual amount related to such increases will be determined at audit and is retrospectively settled.

08. Property Reimbursement. The property reimbursement component is calculated in accordance with Sections V. and VI.

09. Revenue Offset. Revenues from products or services provided to non-patients will be offset from the corresponding rate component(s).

III. Allowable Costs

01. **Accounts Collection.** The costs related to the collection of past due program related costs, such as legal and bill collections fees.

02. **Auto and Travel Expense**. Maintenance and operating costs of a vehicle used for patient care purposes and travel expense related to patient care. The allowance for mileage reimbursement can not exceed the amount determined reasonable by the Internal Revenue Service (IRS) for the period being reported. Meal reimbursement is limited to the amount that would be allowed by the state for a state employee.

03. **Bad Debts**. Payments for efforts to collect past due Title XIX and Title XXI accounts. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write off are not allowable. However, Title XIX and Title XXI coinsurance amounts are one hundred percent (100%) reimbursable under Medicare Provider Reimbursement Manual (PRM. Section 300).

04. **Bank and Finance Charges**. Charges for routine maintenance of accounts. Penalties for late payments, overdrafts, etc., are not allowable.

05. **Compensation of Owners.** An owner may receive reasonable compensation for services subject to the limitations in 4.19-D, to the extent the services are actually performed, documented, reasonable, ordinary, necessary and related to patient care. Allowable compensation cannot exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation cannot exceed the average rate. Provisions in IDAPA 16.03.10.274 effective 3/19/07 further limit compensation to owners, or persons related to owners providing administrative services. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following:
    a. Salaries, wages, bonuses and benefits which are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period.
    b. Supplies and services provided for the owner's personal use.
    c. Compensation paid by the facility to employees for the sole benefit of the owner.
    d. Fees for consultants, directors, or any other fees paid regardless of the label.
    e. Keyman life insurance.
    f. Living expenses, including those paid for related persons.

06. **Contracted Service.** All services received under contract arrangements to the extent that they are related to patient care or the sound conduct and operation of the facility.

07. **Depreciation.** Depreciation on buildings and equipment subject to Section VI. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset. The depreciable life of an asset may not be shorter than the useful life prescribed at IDAPA 16.03.10.288.04 (f) (effective 3/17//07) (Estimated Useful Lives of Depreciable Hospital Assets, 2004 revised edition.)

08. **Dues, Licenses and Subscriptions.**

Subscriptions to periodicals related to patient care.

a. Fees for professional and business licenses related to the operation of the facility are allowable.
b. Dues, tuition, and educational fees to promote quality health care services are allowable when the provisions of PRM, Chapter 4, are met.

09. **Employee Benefits.** Employee benefits, including health insurance, vacation, and sick pay to the extent of employer participation. See PRM, Chapter 21 for specifics.

10. **Employee Recruitment**. Costs of advertising for new employees, including applicable entertainment costs.

11. **Entertainment Costs Related to Patient Care.** Entertainment costs related to patient care only when documentation is provided naming the individuals and stating the specific purpose of the entertainment.

12. **Food**. Costs of raw food, not including vending machine items. The provider is only reimbursed for costs of food purchased for patients. Costs for non-patient meals are non-reimbursable. If the costs for non-patient meals cannot be identified, the revenues from these meals are used to offset the costs of the raw food.

13. **Home Office Costs.** Reasonable costs allocated by related entities for home office services in their applicable cost centers.

14. **Insurance.** Premiums for insurance on assets or for liability purposes, including vehicles, to the extent that they are related to patient care.

15. **Interest.** Interest on working capital loans. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable.

16. **Lease or Rental Payments.** Payments for the property cost of the lease or rental of land, buildings and equipment according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, will be reimbursed in the same manner as an owned asset. The cost of leases related to home offices cannot be reported as property costs, but will be allowable based on reasonable cost principles subject to other limitations contained herein.

17. **Malpractice and Public Liability Insurance**. Premiums for malpractice and public liability insurance must be reported as administrative costs.

18. **Payroll Taxes**. The employer's portion of payroll taxes.

19. **Property Costs**. See Section V. and VI. for property cost details.

    a. Free – Standing Facility Property Rental. For free-standing nursing facilities, the property rental rate is paid as described in Section VI.
    b. Hospital – based nursing facilities are paid based on property costs.

20. **Property Insurance**. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class at the end of a facility's fiscal year.

21. **Property Taxes.** Property taxes are allowable for all facilities.

22. **Repairs and Maintenance**. Costs of maintenance and minor repairs when related to the provision of care.

23. **Salaries**. Salaries and wages of all employees engaged in patient care activities or operation and maintenance. However, non nursing home wages are not an allowable cost.

24. **Supplies**. Cost of supplies used in patient care or providing services related to patient care.

25. **Taxes**. The cost of property taxes on assets used in providing patient care. Other taxes are allowable costs as provided in the PRM, Chapter 21. Tax penalties are non-allowable costs.

26. **Utility Costs**. All allowable expenses for heat, electricity, water and sewer.

IV. Non – Allowable Costs

01. **Accelerated Depreciation.** Depreciation in excess of calculated straight line depreciation, except as otherwise provided.

02. **Acquisitions.** Costs of corporate acquisitions, such as purchase of corporate stock as an investment.

03. **Barber and Beauty Shops.** All costs related to running barber and beauty shops.

04. **Charity Allowances.** Cost of free care or discounted services.

05. **Consultant Fees.** Costs related to the payment of consultant fees in excess of the lowest rate available to a facility. It is the provider's responsibility to make efforts to obtain the lowest rate available to that facility. The efforts may include personally contacting possible consultants or advertising. The lowest rate available to a facility is the lower of the actual rate paid by the facility or the lowest rate available to the facility as determined by departmental inquiry directly to various consultants. Costs in excess of the lowest rate available will be disallowed effective thirty (30) days after a facility is notified, unless the provider shows by clear and convincing evidence it would have been unable to comply with state and federal standards had the lowest rate consultant been retained or that it tried to but was unable to retain the lowest rate consultant. This provision does not limit the Department's ability to disallow excessive consultant costs under other sections of administrative code.

06. **Fees.** Franchise fees (See PRM, Section 2133.1.).

07. **Fund Raising.** Certain fund-raising expenses (See PRM, section 2136.2).

08. **Goodwill.** Costs associated with goodwill as defined in IDAPA 16.03.10.011 effective 3/19/07.

09. **Holding Companies.** All home office costs associated with holding companies (See PRM, Section 2150.2A.).

10. **Interest.** Interest to finance non - allowable costs.

11. **Medicare Costs.** All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services.

12. **Non - patient Care Related Activities.** All activities not related to patient care.

13. **Organization.** Organization costs (See PRM, section 2134).

14. **Pharmacist Salaries.** Salaries and wages of pharmacists.

15. **Prescription Drugs**. Prescription drugs.

16. **Related Party Interest**. Interest on related party loans (See PRM Sections 218.1 and 281.2).

17. **Related Party Non-allowable Costs.** All costs non-allowable to providers are non-allowable to a related party, whether or not they are allocated.

18. **Related Party Refunds**. All refunds, allowances and terms, will be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc.

19. **Self – Employment Taxes**. Self –Employment taxes, as defined by the IRS, which apply to facilities.

20. **Telephone Book Advertising**. Telephone book advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in.

21. **Vending Machines**. Costs of vending machines and cost of the product to stock the machine.

V. **Property Costs.** Total property costs are defined as being made up of the following cost categories. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal.

01. **Depreciation.** All allowable depreciation expense including moveable equipment.

Straight line depreciation is used on fixed assets.

02. **Interest.** All allowable interest expense relating to financing building and equipment purchases. Interest on working capital loans will be included as administrative costs.

Interest costs related to the purchase of land, buildings, fixtures or equipment related to patient care are allowable property costs only when the interest costs are payable to unrelated entities.

03. **Property Insurance.** All allowable property insurance. Malpractice insurance, workmen's compensation and other employee related insurances will not be considered to be property costs.

04. **Lease Payments.** All allowable lease or rental payments.

Amortization of leasehold improvements will be included in property costs.

05. **Property Taxes.** All allowable property taxes.

VI. Property Rental Rate Reimbursement. Free standing nursing facilities other than hospital based nursing facilities will be reimbursed a property rental rate. Property taxes and property insurance will be reimbursed as costs exempt from limitations. The property rental rate includes compensation for major movable equipment but not for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. Prior to final audit for free-standing nursing facilities, an interim rate for property reimbursement will be set to approximate the property rental rate as determined by Sections 56-108 and 56-109, Idaho Code (effective 7/1/09).

01. **Property Rental Rate.**

a. The property rental rate is based upon current construction costs, the age of the facility, the type of facility, and major expenditures made to improve the facility, or a rate based upon property costs as of January 1, 1985.

b. The amount paid for each Medicaid day of care is R = "Property Base" x 40 - "Age" / 40 x "change in building costs", as defined in IDAPA 16.03.10.275.01 (effective 3/19/07).

c. In the event that new requirements are imposed by state or federal agencies, the Department will reimburse the expenditures directly related to these requirements as an increase in the property rental rate if the expense is in excess of one hundred dollars ($100) per bed. If the cost related to the requirement is less than one hundred dollars ($100) per bed, the Department will, within twelve (12) months of verification of expenditure, reimburse the Medicaid share of the entire cost of such new requirements, as a one (1) time payment to the facility.

d. At no time will the property rental rate paid to a facility be less than the greater of the rate allowable to that facility on December 31, 1988, the rate allowable immediately following the first opening of a new facility after December 31, 1988, or the rate allowable immediately following the last, if any, age revision after December 31, 1988.

02. Leased Freestanding Nursing Facilities.

a. Provisions in this section do not apply to reimbursement of home office costs. Home office costs will be based on reasonable cost principles.

b. Facilities with leases entered into on or after March 30, 1981, are to be reimbursed in the same way as owned facilities with ownership costs being recognized instead of lease costs.

c. Facilities with leases entered into prior to March 30, 1981, the property rental rate may be adjusted to compensate for increased property costs resulting from facility modifications related to major repairs, replacement, expansion, remodeling, or renovation initiated after January 1, 1985, if the cost would be sufficient to reduce the age of the facility by one (1) year or more according to Section IV.01.d.i. The rate will be revised after the completion of such modifications and will be the greater of the property rental rate previously allowed under Section VI.02, or the actual per diem property costs for the amortization, depreciation, and interest not applicable to the modifications for the reporting period in which the modifications were completed, plus the per diem of the first year amortization of the modification expenses using the American Hospital Association guideline useful life of lives. However, no such rate change will increase the allowable property rental rate by more than three-fourths (3/4) of the difference between the previous rate and the property rental rate that would be allowed for a new building at the time of the proposed rate revision.

d. Where such leases contain provisions that bind the lessee to accept an increased rate, reimbursement will be at a rate per day of care which reflects the increase in the lease rate.

e. Where such leases bind the lessee to the lease and allow the rate to be renegotiated, reimbursement will be at a rate per day of care which reflects an annual increase in the lease rate not to exceed the increase in the consumer price index for renters' costs. After April 1, 1985, if such a lease is terminated or if the lease allows the lessee the option to terminate other than by an option to purchase the facility, the property rental rate will become the amount "R" determined by the formula in Section VI.01 as of the date on which the lease is or could be terminated.

VII. Cost Limits Based on Cost Report. Each July 1st cost limitations will be established for nursing facilities based on the most recent audited cost report. Calculated limitations will be effective for a one (1) year period, from July 1st through June 30th, which is the rate year.

01. **Percentage above Bed-Weighted Median**. Prior to establishing the first "shadow rates" at July 1, 1999, the estimated Medicaid payments under the previous retrospective system for the year period from July 1, 1999, through June 30, 2000, will be calculated. This amount will then be used to model the estimated payments under the case mix system set forth in Section II. The percentages above the bed-weighted median, for direct and indirect costs, will be established at a level that approximates the same amount of Medicaid expenditures as would have been produced by the retrospective system. The percentages will also be established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the retrospective system. Once the percentage is established, it will be used to calculate the limit by multiplying the bed-weighted median per diem direct cost times the calculated percentage for that class of provider. There will be a direct and indirect percentage that is applied to freestanding and urban hospital-based nursing facilities, and a higher direct and indirect percentage that is applied to rural hospital-based nursing facilities. Once established, these percentages will remain in effect for future rate setting periods.

02. **Direct Cost Limits**. The direct cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment (using the Idaho specific inflation index from the Skilled Nursing Facility Market Basket as established by Global Insights Inc., or its successor) from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be normalized and arrayed from high to low, with freestanding and hospital-based nursing facilities included in the same array, and the bed-weighted median will be computed.

03. **Indirect Cost Limits**. The indirect cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment (using the Idaho specific inflation index from the Skilled Nursing Facility Market Basket as established by Global Insights Inc., or its successor) from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with freestanding and hospital-based nursing facilities included in the same array, and the bed-weighted median will be computed.

04. **Limitation on Increase or Decrease of Cost Limits**. Increases in the direct and indirect cost limits will be determined by the limitations calculated in the most recent base year, indexed forward each year from the midpoint of the base year to the midpoint of the rate year by the inflation factor adjustment (using the Idaho specific inflation index from the Skilled Nursing Facility Market Basket as established by Global Insights Inc., or its successor) plus one percent (1%) per annum. The calculated direct and indirect cost limits will not be allowed to decrease below the limitations effective in the base year. The maximum rate of growth on the cost limits, and the minimum cost limitation, will be examined by the oversight committee periodically to determine which factors to use in the calculation of the limitations effective in the new base year and forward.

05. **Costs Exempt from Limitations**. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in Section XIII.

VIII. **Treatment of New Beds.** Facilities that add beds after July 1, 1999, will have their reimbursement rate subjected to an additional limitation for the next three (3) years. This limitation will apply beginning with the first rate setting period which utilizes a cost report that includes the date when the beds were added.

01. **Limitation of Facilities Rate**. The facility's rate will be limited to the bed-weighted average of the following two (2) rates:
    a. The facility's current prospective rate calculated in accordance with Section II; and
    b. The current median rate for nursing facilities of that type, free-standing, rural hospital-based or urban hospital-based, established each July 1st.

02. **Calculation of the Bed-Weighted Average**. The current calculated facility rate is multiplied by the number of beds in existence prior to the addition. The median rate is multiplied by the number of added beds, weighted for the number of days in the cost reporting period for which they were in service. These two (2) amounts are added together and divided by the total number of beds, with the new beds being weighted if they were only in service for a portion of the year. The resulting per diem amount represents an overall limitation on the facility's reimbursement rate. Providers with calculated rates that do not exceed the limitation receive their calculated rate.

03. Exception to New Bed Rate. The following situations will not be treated as new beds for reimbursement purposes:

a. Any beds converted from nursing facility beds to assisted living beds, can be converted back to nursing facility beds within three (3) years and not be classified as new nursing facility beds. When a nursing facility bed has been converted to an assisted living bed for three (3) or more concurrent years and the bed is converted back to a nursing facility bed, it must be treated as a new nursing facility bed.

b. Beds added as a result of expansion plans, which the Department was aware of prior to July 1, 1999, will not be treated as new beds. The facility must have already expended significant resources on the purchase of land, site planning, site utility planning, and development. The existence of adequate land or space at the nursing facility does not by itself constitute a significant expenditure of resources for the purposes of expansion. A written request with adequate supporting documentation for an exception under this provision must have been received by the Department no later than December 31, 1999. In no case will beds added after July 1, 2003, qualify for this exception to the new bed criteria.

c. Beds which are decertified as a requirement of survey and certification due to deficiencies at the facility can be re-certified as existing beds with the approval of the Department.

d. When a facility can demonstrate to the Department that adding beds is necessary to meet the needs of an under served area, these beds will not be treated as new beds. For an existing facility the new beds are reimbursed at the same reimbursement rate for that facility's existing beds. For a new facility, the facility has the opportunity to substantiate to the Department the need for the new beds being added to the community. If the Department finds that the new beds are needed to accommodate documented demand, the facility's rate will be set at a negotiated rate. The negotiated rate will reflect a direct care and an indirect care cost component not to exceed current direct and indirect cost caps. The negotiated rate will be an interim rate, calculated based on budget data to run the nursing facility and the rate will be adjusted quarterly to reflect case mix adjustments. After the first qualifying cost report is filed, that cost report will be used to retrospectively finalize the interim rates back to entry into the program. The facility will have its rate established at the next July 1st date along with the existing facilities.

IX. **Treatment of New Facilities.** Facilities constructed subsequent to July 1, 1999, will be reimbursed at the median rate for skilled care facilities of that type (freestanding or hospital-based) for the first three (3) full years of operation. During the period of limitation, the facility's rate will be modified each July 1st to reflect the current median rate for skilled care facilities of that type. After the first three (3) full years, the facility will have its rate established at the next July 1st with the existing facilities.

X. **Interim Adjustments to Rates As A Result Of New Mandates.** Certain incurred costs, as a result of federal or state legal mandates, are excluded from the cost limit calculations and are subject to retrospective settlement at the discretion of the Department, and could result in changes to the prospective rates to assure equitable reimbursement. Incurred costs must increase a minimum of fifty cents per patient day in order for the Department to adjust interim rates.

01. **Changes of More Than Fifty Cents Per Patient Day in Costs**. Changes of more than fifty cents ($.50) per patient day in costs otherwise subject to the cost limitations incurred by a facility as a result of changes in state or federal laws or rules will be reported separately on the cost report until such time as they can be properly reflected in the cost limits.
    a. The provider will report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. These costs will be reported separately and will not be reimbursed through the rate setting process until the costs are fully represented in the cost data used to establish the cost limitations and rates.
    b. If more than one (1) increase occurs as a result of one (1) or more law or rule changes, the costs from each event are to be reported separately.
    c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise.

02. **Interim Rate Adjustments**. For interim rate purposes, the provider may be granted an increase in its prospective rate to cover such cost increases. A cost statement covering a recent period may be required with justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled.

03. **Future Treatment of Costs**. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at its option, include all of the previously excluded costs related to those increases in the calculation of costs subject to the cost center limits. The intent of this provision is for costs to be exempt from the cost limits until these costs are able to be fully and equitably incorporated into the data base used to project the cost limits. When cost increases which have been excluded from the cap are incorporated in the inflation indices used to set the cost limits, the cost indices will be adjusted to exclude the influence of such changes if the amount included in the index is identified. When the cost limits are set to include previously excluded amounts, any adjustments made to the indices related to the previously excluded costs will be removed.

XI. Minimum Data Set (MDS) Reviews

01. **Facility Review**. The definition of a Picture Date is a point in time when case mix indexes are calculated for every nursing facility based on the residents in the nursing facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the nursing facility's rate for the next quarter. Subsequent to the picture date each facility will be sent a copy of its resident roster (a listing of residents, their Resource Utilization Group (RUG) classification, case mix index, and identification as Medicaid or other). It will be the facility's responsibility at that time to review the roster for accuracy. If the roster is accurate, the facility will sign and return the roster for rate setting. If any errors are detected, those errors will be communicated to the Department in writing along with any supporting documentation. If the signed resident roster is not returned and no errors are communicated to the Department, the original resident roster will be used for rate setting. Once the resident roster has been used for rate setting, it will be considered final unless modified by subsequent Departmental review.

02. **Departmental Review**. If a departmental review of the MDS data reveals errors that result in an incorrect case mix index, the provider's rate will be retroactively adjusted, for all quarters containing the incorrect assessment, and an amount due to or from the Department will be calculated. This does not include residents who received the default classification due to incomplete or inconsistent MDS data.

XII. Special Rates. A special rate consists of a facility's daily reimbursement rate for a patient plus an add-on amount. Section 56-117 of Idaho Code (effective 7/1/09), provides authority for the Department to pay facilities an amount in addition to the daily rate when a patient has needs that are beyond the scope of facility services and when the cost of providing for those additional needs is not adequately reflected in the rates calculated pursuant to the principles found in Section 56-102 of Idaho Code (effective 7/1/09). This special rate add-on amount for such specialized care is in addition to any payments made in accordance with other provisions of this chapter and is excluded from the computation of payments or rates under other provisions of Section 56-102 of Idaho Code (effective 7/1/09).

01. **Determination**. The Department determines to approve a special rate on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request must be based on an identified condition that will continue for a period greater than two (2) weeks.

02. **Effective Date.** Upon approval, a special rate is effective on the date the application was received, unless the provider requests a retroactive effective date. Special rates may be retroactive for up to thirty (30) days prior to receipt of the application.

03. **Reporting.** Costs equivalent to payments for special rate add-on amounts must be removed from the cost components subject to limits, and be reported separately by the provider.

04. **Limitation**. A special rate cannot exceed the provider's charges to other patients for similar services.

05. **Determination of Payment for Qualifying Residents**. Special rate add-on amounts are calculated using one (1) of the following methods:

a. Special Care Units. If a facility operates a special care unit, such as a behavioral unit or a Traumatic Brain Injury (TBI) unit, reimbursement is determined as described below.

i. If the facility is below the direct care cost limit with special care unit costs included, no special rate is paid for the unit.

ii. If the facility is over the direct care cost limit with special care unit costs included, a special rate add-on amount will be calculated. The special rate add-on amount for the unit is the lesser of the per diem amount by which direct care costs exceed the limit or a calculated add-on amount. The calculated special rate add-on is derived as follows: each Medicaid resident is assigned a total rate equal to the Medicare rate that would be paid if the resident were Medicare eligible. The resident's acuity adjusted Medicaid rate, based on each resident's individual Medicaid CMI, is subtracted from the Medicare rate. The average difference between the Medicaid and the Medicare rates for all special care unit residents is the calculated special rate add-on amount. The calculated special rate add-on amount is compared to the per diem amount by which the provider exceeds the direct care limit. The lesser of these two amounts is allowed as the special rate add-on amount for the unit.

iii. New Unit Added After July 1, 2000. The Department must approve special rates for new special care units or increases to the number of licensed beds in an existing special care unit. Since a new unit will not have the cost history of an existing unit, the provider's relationship to the cap will not be considered in qualifying for a special rate. New units approved for special rates will have their special add-on amount calculated as the difference between the applicable Medicare price under the prospective payment system (PPS), and the acuity adjusted Medicaid rate for all unit residents as explained in Section XII.05a.ii. However, the average of these amounts is not limited to the amount the provider is over the direct care cost limit, as the costs of the unit are not in the rate calculation.

iv. One Hundred Percent (100%) Special Care Facility Existing July 1, 2000. If on July 1, 2000, an entire facility was a special care unit which included Medicaid residents, the facility's direct care cost per diem will not be subject to the direct care cost limit. However, the direct care costs are case mix adjusted based on the ratio of the facility's Medicaid CMI for the rate period to the facility-wide CMI for the cost reporting period.

v. Unit Routine Customary Charge. If the cost to operate a special care unit is being included in a facility's rate calculation process, the facility must report its usual and customary charge for a semi-private room in the unit on the quarterly reporting form, in addition to the semi-private daily room rate for the general nursing home population. A weighted average routine customary charge is computed to represent the composite of all Medicaid residents in the facility based on the type of rooms they occupy, including the unit.

b. The Department currently does not have a bid system in place. Equipment and non-therapy supplies not adequately addressed in the current RUG system, such as CPAP/BIPAP machines, specialized mattresses, specialized beds, specialized wheelchairs, wound VACs, wound VAC supplies, and augmentative communication devices (ACDs), as determined by the Department, are reimbursed at invoice cost as an add-on amount.

c. Ventilator Dependent Residents and Residents Receiving Tracheostomy Care. The facility need not exceed the direct care limit to receive a special rate for ventilator care and Tracheostomy care. In the case of ventilator dependent and Tracheostomy residents, a two (2) step approach is taken to establish an add-on amount. The first step is the calculation of a staffing add-on for the cost, if any, of additional direct care staff required too meet the exceptional needs of these residents. The add-on is calculated following the provisions in Section XII.05.d, adjusted for the appropriate skill level of care staff. The second step is the calculation of an add-on for equipment, supplies, or both up to the invoice cost or rental amount. The combined amount of these two (2) components is considered the special add-on amount to the facility's rate for approved residents receiving this care.

d. Residents Not Residing in a Special Care Unit Requiring one-to-one Staffing Ratios. Facilities may at times have residents who require unusual levels of staffing, such as one-to-one staffing ratios. If the resident qualifies for a special rate, an hourly add-on rate is computed for reimbursement of approved one-to-one (1 to 1) hours in excess of the minimum staffing requirements in effect for the period. The hourly add-on rate is equal to the current Weighted Average Hourly Rate (WAHR) Certified Nursing Assistant (CNA) wage rate plus a benefits allowance of thirty percent (30%), then weighted to remove the CNA Minimum daily staffing time.

e. Varying Levels of One-to-One Care. For varying levels of one-to-one care, such as eight (8) hours or twenty-four (24) hours, the total special rate add-on amount is calculated as the number of hours approved for one-to-one care times the hourly add-on rate as described above. The Weighted Average Hourly Rate (WAHR) CNA wage rate as described in Section 307 of these rules will be updated prior to the July 1st rate setting each year. Should the WAHR survey be discontinued, the Department may index prior amounts forward, or conduct a comparable survey.

06. **Treatment of the Special Rate Cost for Future Rate Setting Periods**. Special rates are established on a prospective basis similar to the overall facility rate. When the cost report used to set a prospective rate contains non-unit special rate cost, an adjustment is made to "offset," or reduce costs by an amount equal to total incremental revenues, or add-on payments received by the provider during the cost reporting period. The amount received is calculated by multiplying the special rate add-on amount paid for each qualifying resident by the number of days that were paid. No related adjustment is made to the facility's CMIs.

XIII. Occupancy Adjustment Factor – In order to equitably allocate fixed costs to the Medicaid patients in cases where a facility is not maintaining reasonable occupancy levels, an adjustment will be made. No occupancy adjustment will be made against the costs that are used to calculate the property rental rate; however adjustment will be made against all other property costs. The adjustment will be made as follows:

01. **Occupancy Levels**. If a facility maintains an average occupancy of less than eighty percent (80%) of a facility's capacity, the total property costs not including cost paid under the property rental rate, will be prorated based upon an eighty percent (80%) occupancy rate. Property costs and property rental rates are defined in Section III. The facility's average occupancy percentage will be subtracted from eighty percent (80%) and the resultant percentage will be taken times the total fixed costs to determine the non-allowable fixed costs.

02. **Occupancy Adjustment**. For purposes of an occupancy adjustment, facility capacity will be computed based upon the greater of the largest number of beds for which the facility was licensed during the period being reported on or the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been converted to use for non-routine nursing home activities or the facility is newly constructed and has entered the Medicaid Program subsequent to January 1, 1982. If the facility's designed capacity has been changed, the number of beds used to determine occupancy will be lowered by the amount of capacity being converted to non-routine nursing home activities. Facility capacity for a new facility will be based on the number of beds approved by the certificate of need process less any capacity converted to non-routine nursing home activities.

03. **Fixed Costs**. For purposes of an occupancy adjustment fixed costs will be considered all allowable and reimbursable costs reported under the property cost categories.

04. **Change in Designed Capacity**. In cases where a provider changes the designed capacity of a facility, the average occupancy for the period prior to the change and subsequent to the change will be computed and each period will be adjusted separately. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure.

05. **New Facility**. In the case of a new facility being licensed and occupied, the first six (6) months' occupancy level will not be subject to this adjustment.

XIV. Recapture of Depreciation. Where depreciable assets that were reimbursed based on cost and were used in the Medicaid Program by a facility subsequent to January 1, 1982, and for which depreciation has been reimbursed by the Program, are sold for an amount in excess of their net book value, depreciation so reimbursed will be recaptured from the buyer of the facility in an amount equal to reimbursed depreciation after January 1, 1982, or gain on the sale, whichever is less.

01. **Amount Recaptured**. Depreciation will be recaptured in full if a sale of a depreciated facility takes place within the first five (5) years of a seller's ownership. Credit will be given for the period of ownership prior to January 1, 1982. For every year the asset is held beyond the first five (5) years, the total depreciation recaptured will be reduced by ten percent (10%) per year of the total depreciation taken.

02. **Time Frame**. Depreciation will be recaptured by the Medicaid Program from the buyer of the facility over a period of time not to exceed five (5) years from the date of sale, with not less than one-fifth (1/5) of the total amount being recaptured for each year after such date.

449. SUPPLEMENTAL PAYMENTS

01. SUPPLEMENTAL PAYMENTS FOR STATE AND COUNTY-OWNED NURSING HOME FACILITIES.

Subject to the provisions of this section, eligible providers of Medicaid nursing home facility services shall receive a supplemental payment each state fiscal year. Eligible providers are state and county owned nursing home facilities.

The supplemental payments are intended to be used to improve access to health care. The payments made to these facilities will be based on the aggregate difference in the actual amount paid by the Medicaid program and the amount that would have been paid under Medicare payment principles.

The supplemental payments shall not be subject to rules governing payments to nursing home facilities found in IDAPA 16.03.10. However, they shall not exceed the Medicaid upper payment limits for non-state governmental-owned or -operated nursing home facility payments. The Medicaid upper payment limit (UPL) analysis will be performed prior to making the supplemental payments.

The computation of the Medicaid UPL will utilize the latest complete State fiscal year average of daily reimbursement rates for each nursing facility, adjusted to a comparable Medicare level (through the addition of actual facility-specific payments for pharmaceutical, laboratory, X-ray, and add-on payments paid during the same State fiscal year as the rate averaging). The adjusted Medicaid rate is then subtracted from the average Medicare rate for the same time period, with the result then multiplied by the Medicaid days from the nursing facility's cost report (e.g. for State fiscal year 2010, the cost report with an ending date in CY 2008, will be used to calculate the Medicaid days) to arrive at the facility's contribution to the group's aggregate UPL room (over/under the UPL).

The State will make equal quarterly supplemental payments (based on a yearly calculation that is divided by four), for each State fiscal year based on a calculation that utilizes the previous calendar year's Medicaid days from the nursing facilities cost report (e.g. for State fiscal year 2010, the cost reports with an ending date in CY 2008, will be used to calculate the Medicaid days). Supplemental payments made to state and county owned nursing homes that provide nursing facility services will be distributed to all nursing facilities within that group based on a previous calendar year's proportionate share of Medicaid days from the nursing facilities cost report compared to the total amount of Medicaid days provided by these state and county owned nursing homes. The State fiscal year 2010 supplemental payments will be distributed based on the 2008 calendar year's Medicaid days. For each succeeding State fiscal year, the State will utilize the previous calendar year's nursing facility cost report Medicaid days for each nursing facility.

02. SUPPLEMENTAL PAYMENTS FOR PRIVATE NURSING HOME FACILITIES.

Subject to the provisions of this section, eligible providers of Medicaid nursing home facility services shall receive a supplemental payment each state fiscal year. Eligible providers are private nursing home faculties.

The supplemental payments are intended to be used to improve access to health care. The payments made to these facilities will be based on the aggregate difference in the actual amount paid by the Medicaid program and the amount that would have been paid under Medicare payment principles.

The supplemental payments shall not be subject to rules governing payments to nursing home facilities found in IDAPA 16.03.10. However, they shall not exceed the Medicaid upper payment limits (UPL) for private nursing home facility payments. The Medicaid upper payment limit analysis will be performed prior to making the supplemental payments.

The computation of the Medicaid UPL will utilize the latest complete State fiscal year average of daily reimbursement rates for each nursing facility, adjusted to a comparable Medicare level (through the addition of actual facility-specific payments for pharmaceutical, laboratory, X-ray, and add-on payments paid during the same State fiscal year as the rate averaging). The adjusted Medicaid rate is then subtracted from the average Medicare rate for the same time period, with the result then multiplied by the Medicaid days from the nursing facility's cost report (e.g. for State fiscal year 2010, the cost report with an ending date in CY 2008, will be used to calculate the Medicaid days) to arrive at the facility's contribution to the group's aggregate UPL room (over/under the UPL).

Supplemental payments made to the private nursing facilities are governed by Idaho Code 56-1501 passed in the 2009 legislative session. The State will make equal quarterly supplemental payments (based on a yearly calculation that is divided by four) for each State fiscal year based on a calculation that utilizes the previous calendar year's Medicaid days from the nursing facilities cost report (e.g. for State fiscal year 2010, the cost reports with an ending date in CY 2008, will be used to calculate the Medicaid days). Supplemental payments made to private nursing homes that provide nursing facility services will be distributed to all nursing facilities within that group based on a previous calendar year's proportionate share of Medicaid days from the nursing facilities cost report compared to the total amount of Medicaid days provided by these private nursing homes. The State fiscal year 2010 supplemental payments will be distributed based on the 2008 calendar year's Medicaid days. For each succeeding State fiscal year, the State will utilize the previous calendar year's nursing facility cost report Medicaid days for each nursing facility.