Dear Senators LODGE, Broadsword & Werk, and
Representatives BLOCK, Nielsen & Henbest:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of the Dept. Of Health & Welfare:

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits (Docket No. 16-0310-0802).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative Services. The final date to call a meeting on the enclosed rules is no later than 10-29-08. If a meeting is called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis from Legislative Services. The final date to hold a meeting on the enclosed rules is 11-27-08.

______The germane joint subcommittee may request a statement of economic impact with respect to a proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement, and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has been held.

To notify Research and Legislation, call 334-2475, or send a written request to the address or FAX number indicated on the memorandum enclosed.

# MEMORANDUM

**TO:** Rules Review Subcommittee of the Senate Health & Welfare Committee and the House Health & Welfare Committee

**FROM:** Research & Legislation Staff - Paige Alan Parker

**DATE:** October 9, 2008

**SUBJECT:** Department of Health and Welfare - IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits (Docket No. 16-0310-0802) (Proposed)

This temporary and proposed rule docket 16-0310-0802 (hereinafter "proposed rule") represents the Department of Health and Welfare's amendments to chapter 16.03.10 dealing with Medicaid enhanced plan benefits.

According to the Department, the proposed rule is authorized pursuant to sections 56-102, 56-135 and 56-202(b), Idaho Code.

Section 56-102, Idaho Code, lists the principles that are to apply to the reimbursement of freestanding skilled care and hospital-based skilled care facilities. Payments to facilities must be through a prospective cost-based system which includes facility-specific case mix adjustments, the details of which are to be set forth in rules based on negotiations between the Department and state associations representing freestanding skilled care facilities and hospital-based skilled care facilities. Section 56-102(1). Section 5-135, Idaho Code, grants the Department's director the authority to promulgate administrative rules as are necessary to carry out the policies and purposes of chapter 1, title 56, Idaho Code, dealing with payment for skilled and intermediate services. Section 56-202(b), Idaho Code, provides the Department with general and broad rulemaking authority.

According to the Department this rule chapter is being amended to: clarify how reimbursement rates for nursing facilities are calculated so that providers can effectively manage their facilities; remove specific dates to refer to the rate base year; and clarify the factors for determining a distressed facility to provide for an annual review, prospective application and facility-by-facility determination.

According to the Department, no fee or charge is imposed by the proposed rule. The Department states that there is no anticipated fiscal impact to the state General Fund as a result of this rule. According to the Department, negotiated rulemaking was conducted with Medicaid providers, the Idaho Health Care Association, Medicaid staff and other stakeholders.

A public hearing is scheduled in Boise on October 8, 2008. All written comments must be directed and delivered to the Department's specified representative on or before October 22, 2008.

## ANALYSIS

The proposed rule provides that the prospective nursing facility rates are recalculated annually with quarterly adjustments for case mix. Section 257. The proposed rule clarifies that the "rate year" for nursing facility is the one year period from July 1 through June 30. Section 258. With regard to limitations on increase of cost limits, the proposed rule provides that increases in the direct and indirect cost limits are to 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 plus two percent. The maximum rate of growth on the cost limits and the minimum cost limitation will be examined periodically by the oversight committee to determine which factors to use in the calculation of the limitations effective in the new base year and forward. Section 258.04.

The Department may negotiate a reimbursement rate different than the rate then in effect for a nursing facility where a change of ownership of an existing facility results in new providers, if the Department determines that such a facility is operationally or financially unstable. Section 261. The Department may also negotiate a reimbursement rate different than the rate then in effect if the Department determines that a facility is located in an under-served area or addresses an under-served need. Under the proposed rule, such a facility no longer need be operationally or financially unstable. Section 263.01.

The proposed rule provides a new list of discretionary factors to be used to determine if a higher rate is required for a nursing facility located in an under-served area or meets an under-served need. Section 263.02. These factors are:

1. The exercise of prudent spending and cost allocation practices (as evidenced by the Department's thorough and comprehensive review of the facility's accounts);
2. For causes beyond the facility's reasonable control, the facility has persuaded the Department that it cannot cover its costs of care, hire qualified staff and otherwise operate effectively and efficiently despite its conscientious and diligent attempts to do so;
3. For facilities that receive special rates for certain difficulty-of-care patients, the same cost of care used to determine those special rates will not be applied toward a determination of distressed facility status (because the special rate meets that need);
4. The determination of whether the distressed facility's distress stems from patient reimbursed care costs or from expenses unrelated to patient care costs; and

5. A limit on distressed facility payments at the lower of its actual costs or customary charge to private-pay patients, as required by federal law, subject to the exceptions in federal law.

Distressed facility payments are presumed to be short-term in nature and must be requested and re-justified for each subsequent fiscal year. Section 263.03. Distressed facility status will not be applied to retroactive rate years. Section 263.04. Multiple facilities under common ownership must independently establish distress on their own merits. Section 263.05.

The proposed rule deletes the formulas to be used by the director appointed oversight committee to examine the inflation factors used to inflate costs forward for rate setting, to limit the growth in the cost component limitations and to determine the minimum cost component limitations. Section 271.

**SUMMARY**

A number of technical issues are noted in the above analysis. However, the Department's proposed rule appears to be authorized under sections 56-102, 56-135 and 56-202(b), Idaho Code.

cc: Department of Health and Welfare
Eric Anderson

# IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

## 16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

## DOCKET NO. 16-0310-0802

## NOTICE OF RULEMAKING - PROPOSED RULE

**AUTHORITY:** In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-102, 56-135, and 56-202(b), Idaho Code.

**PUBLIC HEARING SCHEDULE:** A public hearing concerning this rulemaking will be held as follows:

**WEDNESDAY - OCTOBER 8, 2008 - 2:00 pm**

**DEPARTMENT OF HEALTH & WELFARE**
**Medicaid Office - Conference Room D-East**
**3232 Elder Street, Boise, ID**

The hearing site will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

**DESCRIPTIVE SUMMARY:** The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These rules are being amended to clarify how reimbursement rates for nursing facilities are calculated so that providers can effectively manage their facilities. Language regarding specific dates are being removed to refer to the rate base year. The factors for determining a distressed facility are being clarified to provide for an annual review, prospective application, and a determination on a facility-by-facility basis.

**FEE SUMMARY:** The following is a specific description of the fee or charge imposed or increased: N/A

**FISCAL IMPACT:** The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year.

This rulemaking has no anticipated fiscal impact to the state general fund.

**NEGOTIATED RULEMAKING:** Pursuant to 67-5220(1), Idaho Code, negotiated rulemaking was conducted with Medicaid providers, Idaho Health Care Association, Medicaid staff, and other stakeholders.

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Eric Anderson at (208) 364-1918.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 22, 2008.

DATED this 18th day of August, 2008.

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

**THE FOLLOWING IS THE TEXT OF DOCKET 16-0310-0802**

**257. NURSING FACILITY - DEVELOPMENT OF THE RATE.**
Nursing facility rates are prospective, with new rates effective July 1st of each year, and ~~*rebased*~~ are recalculated annually with quarterly adjustments for case mix. The rate for a nursing facility is the sum of the cost components described in Subsection 257.04 through 257.09 of ~~*these*~~ this rules. 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. ~~*(3-19-07)*~~(____)

**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 (for example, an October 1 CMI would represent the fiscal quarter ended September 30th). (3-19-07)

**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. (3-19-07)

**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. (3-19-07)

**04. Direct Care Cost Component**. The direct care cost component of a nursing facility's rate is determined as follows: (3-19-07)

**a.** The direct care per diem cost limit applicable to the rate period for a nursing facility type (free-standing and urban hospital-based nursing facility or rural hospital-based nursing facility) 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. (3-19-07)

**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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

**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. (3-19-07)

**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 seventy percent (70%). 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. (3-19-07)

**07. Costs Exempt From Limitation**. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates as defined in Section 264 of these rules. (3-19-07)

**08. Property Reimbursement**. The property reimbursement component is calculated in accordance with Section 275 and Subsection 240.19 of these rules. (3-19-07)

**09. Revenue Offset**. Revenues from products or services provided to nonpatients will be offset from the corresponding rate component(s) as described in Section 257 of these rules. (3-19-07)

**258. NURSING FACILITY - COST LIMITS BASED ON COST REPORT.**
~~*Effective July 1, 1999, and e*~~Each July 1st ~~*thereafter,*~~ cost limitations will be established for nursing facilities based on the most recent audited cost report with an end date of June 30th of the previous year or before. Calculated limitations will be effective for a one (1) year period, from July 1 through June 30th of each year, which is the rate year. ~~*(3-19-07)*~~(____)

**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 Sections 255 through 257 of these rules. 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. (3-19-07)

**02. Direct Cost Limits**. The direct 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 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. (3-19-07)

**03. Indirect Cost Limits**. 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. (3-19-07)

**04. Limitation on Increase or Decrease of Cost Limits**. Increases in the direct and indirect cost limits will be determined by the limitations calculated ~~*effective July 1, 1999*~~ 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 plus two percent (2%) per annum. ~~*Furthermore, t*~~The calculated direct and indirect cost limits will not be allowed to decrease below the ~~*established*~~ limitations effective ~~*July 1, 1999*~~ 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 ~~*after a three-year*~~ periodically to determine which factors to use in the calculation of the limitations effective ~~*July 1, 2002*~~ in the new base year and forward. ~~*(3-19-07)*~~(____)

**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 278 of these rules. (3-19-07)

***(BREAK IN CONTINUITY OF SECTIONS)***

**261. NURSING FACILITY - TREATMENT OF A CHANGE IN OWNERSHIP.**

New providers resulting from a change in ownership of an existing facility will receive the previous owner's rate until such time as the new owner has a cost report which qualifies for the rate setting criteria established under these rules. If the Department determines that such a facility is operationally or financially unstable, the Department may negotiate a reimbursement rate different than the rate then in effect for the facility. ~~*(3-19-07)*~~( )

***(BREAK IN CONTINUITY OF SECTIONS)***

**263. NURSING FACILITY - DISTRESSED FACILITY.**

**01. Determination**. If the Department determines that a facility ~~*is operationally or financially unstable,*~~ is located in an under-served area, or addresses an under-served need, the Department may negotiate a reimbursement rate different than the rate then in effect for that facility. ~~*(3-19-07)*~~( )

**02. Discretionary Factors**. The fact that a facility may be located in an under-served area or meets an under-served need does not guarantee increased reimbursement. In exercising its discretion to apply a higher rate, the Department will consider the factors as described in Subsections 263.02.a. through 263.02.e. of this rule. ( )

**a.** Prudent spending patterns. The facility has exercised prudent spending and cost allocation practices, as evidenced by a thorough and comprehensive review of the facility's accounts by the Department. ( )

**b.** Reasonable attempts to remedy problems. The facility must persuade the Department that it has conscientiously and diligently attempted to cover its costs of care, hire qualified staff and otherwise operate effectively and efficiently, but for causes beyond the facility's reasonable control, it has not been able to do so. ( )

**c.** Facility already receives special rates. When a facility already receives special rates for certain difficulty-of-care patients from the Department, the same costs of care that were used to determine special rates will not be applied toward a determination of distressed facility status, because the special rate meets that need. ( )

**d.** Direct and indirect costs of care apportioned to patient care. The Department reimburses the costs of patient care, and does not pay for indirect costs not associated with patient care. The determination of distressed status will focus on whether the facility's distress stems from patient care costs, or whether the distress arises from expenses unrelated to patient care costs ( )

**e.** Existing cost limits.Under no circumstances may a facility's reimbursement exceed the lower of its actual costs or customary charge to private-pay patients, as required by federal law, subject to the exceptions in federal law. The Department's cost caps can be exceeded through the distressed facility process, but to an amount no greater than the federal upper payment limit. ( )

**03. Annual Review**. Distressed facility payments are assumed to be short-term in nature. Each distressed payment must be re-requested and re-justified for each subsequent fiscal year that the facility desires the distressed facility rate. ( )

**04. Prospective Application**. Distressed facility status will be applied only to facilities that are currently distressed or entering a period of distress. Distressed facility status will not be applied to retroactive rate

years. ( )

**05. Facility by Facility Basis**. Each facility must independently establish distress on its own merits, whether or not other facilities with a common owner may also be experiencing distress. ( )

***(BREAK IN CONTINUITY OF SECTIONS)***

**271. NURSING FACILITY - OVERSIGHT COMMITTEE.**

The Director will appoint an oversight committee to monitor implementation of the Prospective Payment System (PPS) for nursing facility reimbursement ~~*that takes effect July 1, 1999*~~. The committee will be made up of at least one (1) member representing each of the following organizations: the Department, the state association~~(s)~~ representing free standing skilled care facilities, and the state association~~(s)~~ representing hospital-based skilled care facilities. The committee will continue to meet periodically subsequent to the implementation of the PPS. ~~*After three (3) years of implementation, the committee will examine the inflation factors used to inflate costs forward for rate setting (DRI + one percent (+1%), the inflation factors used in limiting the growth in the cost component limitations (DRI + two percent (+2%), and the level of the minimum cost component limitations (not lower than limits established July 1, 1999).*~~ ~~*(3-19-07)*~~( )