Dear Senators LODGE, Broadsword & LeFavour, and
Representatives BLOCK, Nielsen & Rusche:

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

IDAPA 16.03.05 - Rules Governing Eligibility for Aid to the Aged, Blind & Disabled (AABD) (Docet #16-0305-0902 - Fee Rule);

16.03.09 - Medicaid Basic Plan Benefits (Docket #16-0309-0901);

16.03.18 - Rules Governing Medicaid Cost-Sharing (Docket #16-0318-0901 - Fee Rule).

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 7-14-09. 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 8-11-09.

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: June 23, 2009

SUBJECT: Department of Health and Welfare:
IDAPA 16.03.05 - Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD) (Docket No. 16-0305-0902) (Fee);
IDAPA 16.03.09 - Medicaid Basic Plan Benefits (Docket No. 16-0309-0901) (Temporary and Proposed); and
IDAPA 16.03.18 - Rules Governing Medicaid Cost-Sharing (Docket No. 16-0318-0901) (Fee)

These dockets 16-0305-0902 (fee); 16-0309-0901(temporary and proposed) and 16-0318-0901 (fee), collectively hereinafter "proposed rules") represent the Department of Health and Welfare's efforts to cut costs in the Medicaid program in response to HB322 (2009), which contained the following legislative intent:

> SECTION 8. COST CONTAINMENT MEASURES. Within this Medicaid appropriation, the Department of Health and Welfare is requested to proceed with implementing the necessary policy and operational changes to contain and reduce costs in order to provide for a sustainable Medicaid Program. Key cost containment strategies should include, but are not limited to, the following:
> (1) Establish cost sharing requirements based on ability to pay for families whose children are eligible for Home Care for Certain Disabled Children (commonly known as the Katie Beckett Program).
> (2) Evaluate Medicaid Managed Care Programs to determine whether cost savings objectives have been met. If the objectives of those arrangements that include access, quality and cost have not been realized, initiate appropriate changes and report back to the Legislature on evaluation outcomes and changes made to meet the objectives.
> (3) Pursue cost reductions through reviewing a possible implementation of a transportation brokerage model.

(4) Implement utilization management approaches to ensure that the amount, duration and scope of services are appropriate to meet the health needs of Medicaid participants.
(5) Monitor institutional cost drivers and make necessary changes to contain costs.
(6) Implement program administrative and policy changes to encourage coverage through cost effective premium assistance programs.
(7) Establish operational protocols and related policy where needed to encourage service providers to obtain national accreditation and establish a provider fee schedule for licensing, surveys and certification as defined by state requirements.
(8) Review the assessment process within the enhanced plan for developmental disabilities services and incorporate any identified cost containment, quality assurance and efficiency measures.

The temporary rule in Docket No. 16-0309-0901, dealing with Medicaid basic plan benefits, became effective on January 1, 2009, in compliance with Executive Order No. 2008-05, dated December 1, 2008, which imposed a four percent 2009 fiscal year General Fund spending reduction for all departments.

According to the Department, the proposed rules are authorized pursuant to sections 56-202, Idaho Code. Section 56-202(b), Idaho Code, provides the Department with general and broad rulemaking authority.

The Department states that additional authority for Docket No. 16-0309-0901 is found in sections 56-203(g) and (i) and 56-250 through 56-257, Idaho Code. Section 56-203(g), Idaho Code, grants the Department the power to define persons entitled to medical assistance in such terms as will meet requirements for federal participation in medical assistance payments. Section 56-203(i), Idaho Code, empowers the Department to determine the amount, duration and scope of care and services to be purchased as medical assistance on behalf of needy, eligible individuals. Sections 56-250 through 56-255, Idaho Code, are the codified provisions of the Idaho Medicaid Simplification Act (HB 776 (2006)). Part of the legislative intent of that Act is to strive to balance efforts to contain Medicaid costs, improve program quality and improve access to services. Section 56-251(1), Idaho Code. Section 56-253(8), Idaho Code, gives the Department's director the authority to promulgate rules consistent with that Act. Sections 56-256 and 56-257, Idaho Code, deal with personal health accounts and copayments, respectively.

In addition, Docket No. 16-0318-0901 is stated to be authorized by sections 56-239 and 56-240, Idaho Code, and by title XXI of the Social Security Act. Section 56-239, Idaho Code, requires the Department's Director to implement the CHIP Plan B program by adopting rules recommended by the Idaho High Risk Reinsurance Pool Board, while section 56-240, Idaho Code, requires the Director to implement the Children's Access Card program by adopting rules recommended by that Board. Title XXI of the Social Security Act is the State Children's Health Insurance Program (SCHIP), which primarily pays for medical assistance for low-income children. The Department does not cite any specific section of that Act as authority for this rulemaking.

According to the Department, the cost sharing imposed by Docket Nos. 16-0305-0902 and 16-0318-0901 is required to meet the legislative intent of HB322. However, no estimate of how much the cost sharing is expected to generate is provided. The Department does not anticipate a fiscal impact to the General Fund due to the Docket No. 16-0305-0902 cost sharing but does anticipate fiscal year 2010 General Fund cost savings of $210,000 resulting from Docket No. 16-0318-0901. The Department states that Docket No. 16-0309-0901, dealing with Medicaid basic plan benefits, will not result in any fee or charge, but will result in fiscal year 2010 General Fund savings of $4,326,650. According to the Department, negotiated rulemaking was not conducted on these proposed rules because the changes were necessary to meet legislative intent.

Public hearings will be scheduled on temporary and proposed Docket No. 16-0309-0901 if requested in writing by 25 persons, a political subdivision or an agency not later than July 15, 2009. Public hearings are scheduled for the two fee rules (Docket Nos. 16-0305-0902 and 16-0318-0901) on July 8th in Idaho Falls, July 9th in Coeur d'Alene, and July 16th in Caldwell. All written comments on the proposed rules are to be directed and delivered to the Department's specified representative on or before July 22, 2009.

ANALYSIS

1. Docket No. 16-0305-0902 (Fee)

Under this docket, certain disabled children may be eligible for Medicaid if the financially responsible adult, with a family income above 150% of the federal poverty guidelines, shares in the cost of the child's Medicaid benefits under IDAPA 16.03.18. Section 785.08.

2. Docket No. 16-0318-0901 (Fee)

IDAPA 16.03.18 provides the rules for Medicaid cost sharing. The heart of Docket No. 16-0318-0901 amends the premiums to be paid according to income levels for participation in Social Security Act title XIX (Medicaid) and XXI (SCHIP) programs. The inclusion of title XXI (SCHIP) is new to this rule. These amendments may be summarized as follows:

Program	Income Level	Premium
XXI	above 133% to 150% FPG	$10 monthly
XIX	same	None
both	above 150% to 185% FPG	$15 monthly
both	above 185% to 300% FPG	3% family income monthly
both	above 300% FPG	4.5% family income monthly

Section 200. Participants funded through title XXI and receiving Medicaid enhanced plan benefits are exempt from these cost sharing provisions. Section 025.02. Failure to pay the premium can make the participant ineligible for coverage unless the participant is eligible as a

"certain disabled child" under IDAPA 16.03.05. Section 200.06.a. This aspect of the fee rule is difficult to reconcile with IDAPA 16.03.05.785.08, as amended by Docket No. 16-0305-0902 (above), which requires cost sharing for certain disabled children pursuant to IDAPA 16.03.18. Under this fee rule, failure to pay the premium for "certain disabled child" participation can result in formal collection against the financially responsible adult. Section 200.06.b.

In addition, this fee docket rule provides definitions for "Title XIX" and "Title "XXI," provides a web link to "Federal Poverty Guidelines (FPG)" and clarifies that "Cost-Sharing" is required of the financially responsible adult and includes both co-pays and premiums. Section 010.

3. Docket No. 16-0309-0901 (Temporary and Proposed)

This docket reduces the percent the Department will reimburse for customary hospital charges from 96.5% to 91.7% of covered separate operating costs. Section 400.09. The docket also reduces the floor calculation for hospital with more than 40 beds from 81.5% to 77.4% of Medicaid costs and reduces the floor calculation for hospitals with 40 or fewer beds from 96.5% to 91.7%. Section 400.25.

SUMMARY

The Department's proposed rule changes are under the rulemaking authority provided by sections 56-202(b), 56-203(i) and 56-253(8), Idaho Code.

cc: Department of Health and Welfare
Tamara Prisock, Susie Cummins, Sheila Pugatch and Robin Pewtress

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND, AND DISABLED (AABD)

DOCKET NO. 16-0305-0902 (FEE RULE)

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2009.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Section 56-202, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be held as follows:

WEDNESDAY JULY 8, 2009 6:00 p.m. MDT	THURSDAY JULY 9, 2009 7:00 p.m. PDT	THURSDAY JULY 16, 2009 5:00 p.m. MDT
State Office Bldg. 150 Shoup Ave. 2nd Floor Lg. Conf. Room Idaho Falls, ID	DHW - Region 1 Office 1120 Ironwood Drive Suite 102, Lg. Conf. Room Coeur d'Alene, ID	DHW - Region III Office 3402 Franklin Road Sawtooth Room Caldwell, ID

The hearing site(s) 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 the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

In order to meet legislative intent for Medicaid cost containment measures in House Bill 322 for the state fiscal year 2010, the Department is implementing changes in this chapter of rule to provide provisions for cost-sharing for Home Care for Certain Disabled Children (HCCDC) also known as Katie Beckett. The premium and actual cost-sharing amounts are provided under IDAPA 16.03.18. "Medicaid Cost-Sharing," Docket No. 16-0318-0901, published in the July 1, 2009, Idaho Administrative Bulletin."

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

These rule changes are needed to meet deadlines in governing law to implement cost containment measures for the state fiscal year 2010.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein:

This cost-sharing measure is required to meet 2010 Legislative intent language in House Bill 322.

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: There is no anticipated fiscal impact to state general funds due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because these cost saving measures are being required to meet legislative intent.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Susie Cummins at (208) 732-1419.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 22, 2009.

DATED this 4th day of June, 2009.

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

THE FOLLOWING IS THE TEMPORARY AND PROPOSED TEXT FOR DOCKET 16-0305-0902

785. CERTAIN DISABLED CHILDREN.
A disabled child, not eligible for Medicaid outside a medical institution, is eligible for Medicaid if he meets the conditions in Subsections 785.01 through 785.0~~7~~8 of these rules. ~~*(3-15-02)*~~(7-1-09)T

01. **Age**. Is under nineteen (19) years old. (7-1-99)

02. **AABD Criteria**. Meets the AABD blindness or disability criteria. (7-1-99)

03. **AABD Resource Limit**. Meets the AABD single person resource limit. (7-1-99)

04. **Income Limit**. Has monthly income not exceeding three (3) times the Federal SSI benefit payable monthly to a single person. (7-1-99)

05. **Eligible for Long Term Care**. Meets the medical conditions for long-term care in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-30-07)

06. **Appropriate Care**. Is appropriately cared for outside a medical institution, under a physician's plan of care. (7-1-99)

07. **Cost of Care**. Can be cared for cost effectively outside a medical institution. The estimated cost of caring for the child must not exceed the cost of the child's care in a hospital, nursing facility, or ICF-MR. (3-15-02)

08. **Share of Cost**. The financially responsible adult of a certain disabled child, who has family income above one hundred fifty percent (150%) of the federal poverty guidelines, is required to share in the cost of the child's Medicaid benefits under the provisions in IDAPA 16.03.18, "Medicaid Cost-Sharing." (7-1-09)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0901

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2009.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; also Executive Order No. 2008-05 and House Bill 322 (2009).

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than Wednesday, July 15, 2009.

The hearing site(s) 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 the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These rules are being amended in response to the Governor's Executive Order No. 2008-05 that directed state agencies to hold back 4% of their state general fund budgets for State Fiscal Year 2009. This reduction is being carried over for the Department's Division of Medicaid for State Fiscal Year 2010 under House Bill 322 (2009). Cost savings under these rule changes will be realized through reduction in reimbursement percentages to Medicaid providers of hospital services.

Medicaid reimbursement for hospitals is based on a percentage of customary charges. This rule change will reduce the current maximum and minimum reimbursement percentages from 96.5% maximum and 81.5% minimum to new percentages of 91.7% maximum and 77.4% minimum. These percentages reflect a 5% decrease in the hospital reimbursement percentages, a reduction from the 10% decrease originally proposed.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate since it is being done to comply with Executive Order No. 2008-05, which created a deadline for compliance.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: NA

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:

The projected savings to the state general fund is approximately $4,326,650. These savings are already reflected in the State Fiscal Year 2010 appropriation.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because these rule changes are being made to comply with Executive Order No. 2008-05 that requires a 4% holdback of the Department's budget for State Fiscal Year 2009 and continued for State Fiscal Year 2010 under House Bill 322 (2009).

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary and proposed rule, contact Sheila Pugatch at (208) 364-1817.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, July 22, 2009.

DATED this 2nd day of June, 2009.

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

THE FOLLOWING IS THE TEMPORARY AND PROPOSED TEXT OF DOCKET NO. 16-0309-0901

400. INPATIENT HOSPITAL SERVICES - DEFINITIONS.

01. Administratively Necessary Day (AND). An Administratively Necessary Day (AND) is intended to allow a hospital time for an orderly transfer or discharge of participant inpatients who are no longer in need of a continued acute level of care. ANDs may be authorized for inpatients who are awaiting placement for nursing facility level of care, or in-home services which are not available, or when catastrophic events prevent the scheduled discharge of an inpatient. (3-30-07)

02. Allowable Costs. The current year's Medicaid apportionment of a hospital's allowable costs determined at final or interim settlement consist of those costs permitted by the principles of reimbursement contained in the Provider Reimbursement Manual (PRM) and do not include costs already having payment limited by Medicaid rate file or any other Medicaid charge limitation. (3-30-07)

03. Apportioned Costs. Apportioned costs consist of the share of a hospital's total allowable costs attributed to Medicaid program participants and other patients so that the share borne by the program is based upon actual services received by program participants, as set forth in the applicable Title XVIII principles of cost reimbursement as specified in the PRM and in compliance with Medicaid reimbursement rules. (3-30-07)

04. Capital Costs. For the purposes of hospital reimbursement, capital costs are those allowable costs considered in the settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes. (3-30-07)

05. Case-Mix Index. The Case-Mix Index for a hospital is the average weight of values assigned to a range of diagnostic related groups, including but not limited to, those used in the Medicare system or adjoining states and applied to Medicaid discharges included in a hospital's fiscal year end settlement. The index will measure the relative resources required to treat Medicaid inpatients. The Case-Mix Index of the current year will be divided by the index of the principal year to assess the percent change between the years. (3-30-07)

06. Charity Care. Charity care is care provided to individuals who have no source of payment, third-party or personal resources. (3-30-07)

07. Children's Hospital. A Medicare-certified hospital as set forth in 42 CFR Section 412.23(d). (3-30-07)

08. Current Year. Any hospital cost reporting period for which reasonable cost is being determined will be termed the current year. (3-30-07)

09. Customary Hospital Charges. Customary hospital charges reflect the regular rates for inpatient or

outpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services billed to the Department. No more than ninety-~~*six*~~one and ~~*a half*~~ seven-tenths percent (~~*96.5*~~ 91.7%) of covered charges will be reimbursed for the separate operating costs for either total inpatient services or total outpatient services at the time of final cost settlement for any fiscal year with the exception set forth in Subsection 405.03.b. of these rules. ~~*(3-30-07)*~~(1-1-09)T

10. Disproportionate Share Hospital (DSH) Allotment Amount. The DSH allotment amount determined by CMS that is eligible for federal matching funds in any federal fiscal period for disproportionate share payments. (3-30-07)

11. Disproportionate Share Hospital (DSH) Survey. The DSH survey is an annual data request from the Department to the hospitals to obtain the information necessary to compute DSH in accordance with Subsection 405.09.a. of these rules. (3-30-07)

12. Disproportionate Share Threshold. The disproportionate share threshold is: (3-30-07)

a. The arithmetic mean plus one (1) standard deviation of the Medicaid Utilization Rates of all Idaho Hospitals; or (3-30-07)

b. A Low Income Revenue Rate exceeding twenty-five percent (25%). (3-30-07)

13. Excluded Units. Excluded units are distinct units in hospitals which are certified by Medicare according to 42 CFR Sections 412.25, 412.27 and 412.29 for exclusion from the Medicare prospective payment system. (3-30-07)

14. Hospital Inflation Index. An index calculated through Department studies and used to adjust inpatient operating cost limits and interim rates for the current year. (3-30-07)

15. Low Income Revenue Rate. The Low Income Revenue Rate is the sum of the following fractions, expressed as a percentage, calculated as follows: (3-30-07)

a. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues and cash subsidies of the hospital for inpatient services in the same cost reporting period; plus (3-30-07)

b. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in the same cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care must not include contractual allowances and discounts and reduction in charges given to Medicare, Medicaid, other third-party payors, or cash for patient services received directly from state and local governments county assistance programs. (3-30-07)

16. Medicaid Inpatient Day. For purposes of DSH payments, an inpatient day is defined as a Medicaid inpatient day in a hospital for which there is also no Medicare inpatient day counted. (3-30-07)

17. Medicaid Utilization Rate (MUR). The MUR for each hospital will be computed using the Department's record of paid inpatient days for the fiscal year divided by the total inpatient days for the same fiscal year as reported in the DSH survey. In this paragraph, the term “inpatient days” includes Medicaid swing-bed days, administratively necessary days, newborn days, days in specialized wards, days provided at an inappropriate level of care, and Medicaid inpatient days from other states. In this paragraph, “Medicaid inpatient days” includes paid days not counted in prior DSH threshold computations. (3-30-07)

18. Obstetricians. For purposes of an adjustment for hospitals serving a disproportionate share of low income patients, and in the case of a hospital located in a rural area, as defined by the federal Executive Office of Management and Budget, the term “obstetrician” includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. (3-30-07)

19. On-Site. A service location over which the hospital exercises financial and administrative control. "Financial and administrative control" means a location whose relation to budgeting, cost reporting, staffing, policy-making, record keeping, business licensure, goodwill and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location must be in close proximity to the hospital where it is based, and both facilities serve the same patient population (e.g. from the same area, or catchment, within Medicare's defined Metropolitan Statistical Area (MSA) for urban hospitals or thirty-five (35) miles from a rural hospital). (3-30-07)

20. Operating Costs. For the purposes of hospital reimbursement, operating costs are the allowable costs included in the cost centers established in the finalized Medicare cost report to accumulate costs applicable to providing routine and ancillary services to patients for the purposes of cost assignment and allocation in the step-down process. (3-30-07)

21. Other Allowable Costs. Other allowable costs are those reasonable costs recognized under the Medicaid reasonable cost principles for services not subject to Medicaid limitations of coverage or reimbursement limits. Costs which are not reimbursed as operating costs, but recognized by Medicare principles as allowable costs will be included in the total reasonable costs. Other allowable costs include, but are not necessarily limited to, physician's component which was combined-billed, capital costs, ambulance costs, excess costs, carry-forwards and medical education costs. (3-30-07)

22. Principal Year. The principal year is the period from which the Medicaid Inpatient Operating Cost Limit is derived. (3-30-07)

a. For inpatient services rendered on or after November 1, 2002, the principal year is the provider's fiscal year ending in calendar year 1998 in which a finalized Medicare cost report or its equivalent is prepared for Medicaid cost settlement. (3-30-07)

b. For inpatient services rendered on or after January 1, 2007, the principal year is the provider's fiscal year ending in calendar year 2003 and every subsequent fiscal year-end in which a finalized Medicare cost report, or its equivalent, is prepared for Medicaid cost settlement. (3-30-07)

23. Public Hospital. For purposes of Subsection 405.03.b. of these rules, a Public Hospital is a hospital operated by a federal, state, county, city, or other local government agency or instrumentality. (3-30-07)

24. Reasonable Costs. Except as otherwise provided in Section 405.03 of these rules, reasonable costs include all necessary and ordinary costs incurred in rendering the services related to patient care which a prudent and cost-conscious hospital would pay for a given item or service which do not exceed the Medicaid cost limit. (3-30-07)

25. Reimbursement Floor Percentage. The floor calculation for hospitals with more than forty (40) beds is ~~*eighty-one*~~ seventy-seven and ~~*a half*~~ four-tenths percent (~~*81.5*~~ 77.4%) of Medicaid costs, and the floor calculation for hospitals with forty (40) or fewer beds is ninety-~~*six*~~one and ~~*a half*~~ seven-tenths percent (~~*96.5*~~ 91.7%).
~~*(4-2-08)*~~(1-1-09)T

26. TEFRA. TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248. (3-30-07)

27. Uninsured Patient Costs. For the purposes of determining the additional costs beyond uncompensated Medicaid costs that may be reimbursed as a DSH payment without exceeding the state Allotment Amount, only inpatient costs of uninsured patients will be considered. An inpatient with insurance but no covered benefit for the particular medically necessary service, procedure or treatment provided is an uninsured patient. (3-30-07)

28. Upper Payment Limit. The Upper Payment Limit for hospital services is defined in the Code of Federal Regulations. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.18 - RULES GOVERNING MEDICAID COST-SHARING

DOCKET NO. 16-0318-0901 (FEE RULE)

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2009.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-239, and 56-240, Idaho Code, and Title XXI of the Social Security Act.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

WEDNESDAY JULY 8, 2009 6:00 p.m. MDT	THURSDAY JULY 9, 2009 7:00 p.m. PDT	THURSDAY JULY 16, 2009 5:00 p.m. MDT
State Office Bldg. 150 Shoup Ave. 2nd Floor Lg. Conf. Room Idaho Falls, ID	DHW - Region 1 Office 1120 Ironwood Drive Suite 102, Lg. Conf. Room Coeur d'Alene, ID	DHW - Region III Office 3402 Franklin Road Sawtooth Room Caldwell, ID

The hearing site(s) 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 the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

In order to meet legislative intent for Medicaid cost containment in House Bill 322 for the state fiscal year 2010, the Department is implementing changes in this chapter to add a cost-sharing premium for Home Care for Certain Disabled Children (HCCDC) also known as Katie Beckett. These requirements implement cost-sharing in the form of a monthly payment based on family income that is remitted to the Department each month. Failure to pay will not affect the child's eligibility, but may result in collection procedures that are also being identified in these rules.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

These rule changes are needed to meet deadlines in governing law to implement cost containment measures for the state fiscal year 2010.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein:

This cost-sharing measure is required to meet 2010 Legislative intent language in House Bill 322.

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:

The cost savings for this rulemaking for SFY 2010 is estimated at $210,000 in state general funds. These savings are already reflected in the State Fiscal Year 2010 appropriation.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because these cost saving measures are being required to meet legislative intent.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Robin Pewtress at (208) 364-1892.

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 July 22, 2009.

DATED this 4th day of June, 2009.

Tamara Prisock
DHW - Administrative Procedures Section
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THE FOLLOWING IS THE TEMPORARY AND PROPOSED TEXT FOR DOCKET 16-0318-0901

010. DEFINITIONS.

01. Co-Payment (Co-Pay). The amount a participant is required to pay to the provider for specified services. (3-19-07)

02. Cost-Sharing. A payment the participant or the financially responsible adult is required to make toward the cost of ~~his~~ the participant's health care. Cost-sharing includes both co-pays and premiums. ~~(4-6-05)~~(7-1-09)T

03. Department. The Idaho Department of Health and Welfare, or a person authorized to act on behalf of the Department. (3-19-07)

04. Federal Poverty Guidelines (FPG). The federal poverty guidelines issued annually by the U. S. Department of Health and Human Services (HHS). The federal poverty guidelines are available on the U.S. Health and Human Services web site at http://aspe.hhs.gov/poverty/index.shtml. ~~(3-19-07)~~(7-1-09)T

05. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-19-07)

06. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-19-07)

07. Premium. A regular and periodic charge or payment for health coverage. (4-6-05)

08. Social Security Act. 42 U.S.C. 101 et seq., authorizing, in part, federal grants to the states for medical assistance to eligible low-income individuals. (3-19-07)

09. State. The state of Idaho. (4-6-05)

10. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program

jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (7-1-09)T

11. **Title XXI**. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (7-1-09)T

011. -- 024. (RESERVED).

025. *PARTICIPANTS* EXEMPTIONS FROM COST-SHARING.

01. **Native American and Alaskan Native Participants**. Native American and Alaskan Native participants are exempt from the cost-sharing provisions of Sections 200 and 300 of these rules. The participant must declare his race to the Department to receive this exemption. *(3-19-07)*(7-1-09)T

02. **Title XXI Participants**. Participants funded through Title XXI and receiving Medicaid Enhanced Plan benefits are exempt from the cost-sharing provisions of Section 200 of these rules. (7-1-09)T

(BREAK IN CONTINUITY OF SECTIONS)

200. PREMIUMS.

01. Family Income Above 133% of FPG. (7-1-09)T

a. Each participant funded by Title XXI and with family income *at or* above one hundred thirty-three percent (133%) of the *Federal Poverty Guideline (*current FPG*)* and equal to or less than one hundred fifty percent (150%) of the FPG must pay a monthly premium of ten dollars ($10) to the Department. *(3-19-07)*(7-1-09)T

b. Each participant funded by Title XIX and with family income above one hundred thirty-three percent (133%) of the current FPG and equal to or less than one hundred fifty percent (150%) of the FPG is not required to pay a premium. (7-1-09)T

02. Family Income Above 150% of FPG. Each participant with family income above one-hundred fifty percent (150%) of the *Federal Poverty Guideline (*current FPG*)* and equal to or less than one-hundred eighty-five percent (185%) of the FPG must pay a monthly premium of fifteen dollars ($15) to the Department. *(3-19-07)*(7-1-09)T

03. **Family Income Above 185% of FPG**. Each participant with family income above one-hundred eighty-five percent (185%) of the current FPG and equal to or less than three hundred percent (300%) of the FPG must pay a monthly premium equal to three percent (3%) of the family income to the Department. (7-1-09)T

04. **Family Income Above 300% of FPG**. Each participant with family income above three-hundred percent (300%) of the current FPG must pay a monthly premium of four and a one-half percent (4.5%) of the family income to the Department. (7-1-09)T

05. **Failure to Provide Information**. The family must provide the Department with information needed to determine family income and household size. Failure to provide information will subject the participant to a monthly premium equal to the average monthly cost of coverage for participants receiving Medicaid Enhanced Plan benefits. (7-1-09)T

0*3*6. Failure to Pay Premium. (7-1-09)T

a. *A participant's f*Failure to pay the premium can make the participant ineligible for coverage unless the participant is eligible as a "Certain Disabled Child" described in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." *(3-19-07)*(7-1-09)T

b. When a participant is eligible as a "Certain Disabled Child," failure to pay the premium can result in formal collection proceedings against the parent, parents, or any other adult financially responsible for the child. The amount owed determines in which court the Department pursues the debt collection of the delinquency. (7-1-09)T

047. Department Responsibilities. (3-19-07)

a. A participant must not be assessed premiums during the time initial eligibility is determined. Obligation for premium payments does not begin for at least sixty (60) days after receipt of application. (3-19-07)

b. A participant must not be assessed premiums for extra months of eligibility received due solely to the Department's late review of continuing eligibility. (3-19-07)

c. A participant must not be assessed premiums for months of retroactive eligibility. (3-19-07)

d. The Department is required to routinely notify a participant of his premium payment obligations including any delinquencies, if applicable. (3-19-07)