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 16.03.10 - Medicaid Enhanced Plan Benefits (Docket No. 16-0310-0903).

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 8-3-09. 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 8-31-09.

_____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: July 15, 2009

SUBJECT: Department of Health and Welfare - IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits (Docket No. 16-0310-0903) (Temporary and Proposed)

This temporary and proposed rule docket 16-0310-0903 (hereinafter "proposed rule") represents the Department of Health and Welfare's amendments to chapter 16.03.10 dealing with Medicaid enhanced plan benefits. The Governor's justification for the temporary rule is said to comply with HB123 (2009), which reduced payment to hospital based skilled care facilities by 2.7 percent for fiscal year 2010 and kept the payments for immediate care facilities for the mentally retarded at the fiscal 2009 rate. HB123 (2009) went into effect on April 1, 2009. The temporary rule was effective on July 1, 2009.

In addition to HB123 (2009), the Department states that the proposed rule is authorized pursuant to sections 56-202(b), 56-203(g) and (i) and 56-250 through 56-257, Idaho Code.

Section 56-202(b), Idaho Code, provides the Department with general and broad rulemaking authority. 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 Co-payments, respectively, and are not relevant to the present proposed rule.

Not listed by the Department as justification for the proposed rule is section 56-1003, Idaho Code, which specifies the powers and duties of the Department's director. Subsection (3) of that section grants the director the authority to adopt rules regarding the general supervision of the promotion and protection of the life, health and mental health of the people of this state.

The Department explains that nursing facilities are reimbursed with a daily rate that is adjusted for inflation and cost changes on an annual basis. The Department states that the proposed rule will realize a cost savings by capping the incentive payment rate at $9.50 per patient day, reduce the inflation index adjustment and the inflation index adjustment costs to zero, and reduce the inflation index adjustment to annual cost limits from two to one percent.

According to the Department, no fee or charge is imposed by the proposed rule. The Department anticipates a projected fiscal savings of $3,479,363 of state and federal matching funds, $724,751 of which would be General Fund savings. The Department states that these projected savings have already been reflected in the 2010 appropriations. According to the Department, negotiated rulemaking was not conducted because the changes were in response to HB123 (2009).

Public hearings will be scheduled if requested in writing by 25 persons, a political subdivision or an agency by July 15, 2009. All written comments were to be directed and delivered to the Department's specified representative on or before July 22, 2009.

ANALYSIS

The proposed rule changes the calculation of the efficiency incentive (available to both free-standing and hospital based nursing facility providers that have inflated per diem indirect care costs less than the indirect per diem cost limit for that type of provider) by multiplying the difference between the per diem indirect cost limit and the facility's inflated per diem indirect care costs by 50 rather than by 70 percent and limits that incentive to $9.50 per patient day. Section 257.06. The proposed rule also limits the increases in the direct and indirect cost limits to the inflation factor plus one percent (rather than two percent). Section 258.04.

SUMMARY

The Department's proposed rule appears to be authorized under sections 56-202(b) and 203(i), Idaho Code.

cc: Department of Health and Welfare
Tamara Prisock & Robert Kellerman

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0903

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 Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code; and HB 123 (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 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 amendments are in response to the passage of HB 123 during the 2009 Legislative session. Cost savings under these rule changes will be realized through reductions in incentive payments to nursing facilities and reductions in percentage increases to the inflation index used to calculate the nursing facility daily reimbursement rate.

Nursing facilities are reimbursed with a daily rate that is adjusted for inflation and increased/decreased costs on an annual basis. This rule change will realize cost savings through establishing a capped incentive payment rate of $9.50 per patient day, reduce the daily reimbursement rate inflation index adjustment from 1% to 0% per year, reduce the inflation index adjustment to costs reported in a nursing facilities annual cost report for purposes of rate setting from 1% to 0%, and reduce the inflation index adjustment to annual cost limits from 2% to 1%.

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: This rulemaking is necessary to comply with HB 123 (2009).

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 fiscal impact is a total savings of $3,479,363; this includes state funds and federal matching funds. The projected savings to the state general fund is approximately $724,751. These savings are already reflected in the State Fiscal Year 2010 appropriation.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 67-5220(2), negotiated rulemaking was not conducted because this rule is being written to comply with changes in Idaho statute.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Robert Kellerman at (208) 364-1994.

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 OF DOCKET NO. 16-0310-0903

257. NURSING FACILITY - DEVELOPMENT OF THE RATE.
Nursing facility rates are prospective, with new rates effective July 1st of each year, and 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 this rule. 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. (5-8-09)

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*~~ fifty percent (~~7~~50%) not to exceed nine dollars and fifty cents ($9.50) 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. ~~*(3-19-07)*~~(7-1-09)T

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.
Each July 1st 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. (5-8-09)

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 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*~~ one percent (~~2~~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. ~~*(5-8-09)*~~(7-1-09)T

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)