

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 123

BY HEALTH AND WELFARE COMMITTEE

AN ACT

1 RELATING TO PUBLIC ASSISTANCE AND WELFARE; AMENDING SECTION  
2 56-102, IDAHO CODE, TO REMOVE AN EXCEPTION FOR THE IDAHO  
3 STATE VETERANS HOMES, TO PROVIDE PRINCIPLES TO APPLY TO THE  
4 REIMBURSEMENT OF THE IDAHO STATE VETERANS HOMES, TO REMOVE  
5 A PROVISION FOR PAYMENT TO SKILLED CARE FACILITIES, TO PROVIDE  
6 AN ADJUSTMENT TO SKILLED CARE FACILITY PROSPECTIVE RATES  
7 WITH AN EXCEPTION, TO PROVIDE A MAXIMUM INCENTIVE PAYMENT  
8 AND TO MAKE TECHNICAL CORRECTIONS; AMENDING SECTION 56-113,  
9 IDAHO CODE, TO PROVIDE FOR THE SAME RATE TO BE PAID TO  
10 INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED FOR  
11 A CERTAIN PERIOD OF TIME AND TO MAKE A TECHNICAL CORRECTION;  
12 AMENDING SECTION 56-136, IDAHO CODE, TO PROVIDE FOR THE SAME  
13 RATE TO BE PAID TO MEDICAID-COVERED PHYSICIAN AND DENTIST  
14 SERVICES FOR A CERTAIN PERIOD OF TIME, TO REVISE THE IDENTITY  
15 OF AN INDEX PUBLISHER AND TO MAKE A TECHNICAL CORRECTION;  
16 AMENDING SECTION 56-255, IDAHO CODE, TO PROVIDE NONEMERGENCY  
17 MEDICAL TRANSPORTATION BENEFITS TO CERTAIN PERSONS AND TO  
18 REMOVE NONEMERGENCY MEDICAL TRANSPORTATION BENEFITS FOR  
19 CERTAIN PERSONS; AMENDING SECTION 56-1401, IDAHO CODE, TO  
20 REVISE LEGISLATIVE INTENT; AMENDING SECTION 56-1402, IDAHO CODE,  
21 TO DEFINE NEW TERMS; AMENDING SECTION 56-1404, IDAHO CODE,  
22 TO PROVIDE FOR THE CALCULATION OF AN UPPER PAYMENT LIMIT  
23 ASSESSMENT RATE AND THE METHODOLOGY THEREFOR, TO PROVIDE FOR  
24 THE CALCULATION OF A DISPROPORTIONATE SHARE ASSESSMENT RATE  
25 FOR CERTAIN HOSPITALS AND THE METHODOLOGY THEREFOR, AND TO  
26 PROVIDE A LIMIT ON ASSESSMENTS FOR CERTAIN HOSPITALS; AMENDING  
27 SECTION 56-1406, IDAHO CODE, TO REVISE TIMING FOR MAKING CERTAIN  
28 PAYMENTS AND TO PROVIDE A CORRECT CODE REFERENCE; AMENDING  
29 SECTION 56-1410, IDAHO CODE, TO REVISE THE CIRCUMSTANCES UNDER  
30 WHICH A CERTAIN ASSESSMENT SHALL NOT TAKE EFFECT OR SHALL  
31 CEASE TO BE IMPOSED; DECLARING AN EMERGENCY AND PROVIDING  
32 RETROACTIVE APPLICATION.  
33

34 Be It Enacted by the Legislature of the State of Idaho:

35 SECTION 1. That Section 56-102, Idaho Code, be, and the same is hereby amended to  
36 read as follows:

37 56-102. PRINCIPLES OF PROSPECTIVE RATES AND PAYMENT. The following  
38 principles shall apply to the reimbursement of freestanding skilled care and ~~hospital-based~~

1 hospital based skilled care facilities and Idaho state veterans homes, with the exception of the  
 2 nursing ~~facilities~~ facility at ~~Idaho state veterans homes and~~ state hospital south, which shall be  
 3 reimbursed costs based on medicare reasonable cost provisions:

4 (1) Payments to facilities shall be through a prospective cost-based system which  
 5 includes facility-specific case mix adjustments. Details of the methodology shall be set forth  
 6 in rules based on negotiations between the department, the state association(s) representing  
 7 freestanding skilled care facilities, and the state association(s) representing ~~hospital based~~  
 8 hospital based skilled care facilities. In no event shall reimbursement to any facility exceed the  
 9 usual and customary charges made to private pay patients; and

10 (2) Each skilled care facility's case mix index shall be calculated quarterly and rates  
 11 shall be adjusted based on the case mix of that facility's medicaid residents as of a certain date  
 12 during the preceding quarter as specified in rule; and

13 (3) ~~In state fiscal year 2000, the total amount paid to skilled care facilities shall~~  
 14 ~~approximate the same amount in medicaid expenditures as would have been paid using the~~  
 15 ~~methodology in effect in state fiscal year 1999, and the percentages of medicaid funds projected~~  
 16 ~~to be paid to freestanding skilled care facilities and hospital based skilled care facilities shall be~~  
 17 ~~the same percentages that are projected to be paid using the methodology in effect during state~~  
 18 ~~fiscal year 1999~~ With the exception of the nursing facilities at Idaho state veterans homes, each  
 19 skilled care facility's quarterly rate will be decreased two and seven-tenths percent (2.7%) from  
 20 July 1, 2009, through June 30, 2010; and

21 (4) The cost limits used for the direct care and indirect care costs of rural ~~hospital based~~  
 22 hospital based skilled care facilities shall be higher than the cost limits used for the direct  
 23 care and indirect care costs of freestanding skilled care and urban ~~hospital based~~ hospital based  
 24 skilled care facilities; and

25 (5) In computing the direct care per diem rate neither medicaid-related ancillary services  
 26 nor raw food shall be case-mix adjusted; and

27 (6) Property costs shall not be subject to a cost limitation or incentive. Property costs  
 28 of freestanding skilled care facilities shall be reimbursed as described in section 56-108, Idaho  
 29 Code, and property costs of urban and rural ~~hospital based~~ hospital based skilled care facilities  
 30 shall be reimbursed as described in section 56-120, Idaho Code; and

31 (7) Cost limits shall apply to direct care costs and indirect care costs. The cost limits  
 32 shall be based on percentages above the bed-weighted median of the combined costs of both  
 33 freestanding skilled care and ~~hospital based~~ hospital based skilled care facilities; and

34 (8) Costs exempt from cost limits are property taxes, property insurance, utilities and  
 35 costs related to new legal mandates as defined by rule; and

36 (9) An incentive payment shall be paid to those facilities with indirect per diem costs  
 37 that are less than the established indirect care cost limit. The incentive payment is calculated  
 38 by taking the difference between the cost limits and the provider's per diem indirect care cost  
 39 times the incentive percentage up to a maximum of nine dollars and fifty cents (\$9.50) per  
 40 patient day. Freestanding skilled care and ~~hospital based~~ hospital based skilled care facilities  
 41 shall receive the same percentage incentive payments for indirect care costs but no incentive  
 42 payment for direct care costs. The percentage at which the incentive payment will be set  
 43 shall be based on negotiations between the department, the state association(s) representing  
 44 freestanding skilled care facilities, and the state association(s) representing ~~hospital based~~  
 45 hospital based skilled care facilities; and

1 (10) A newly constructed facility shall be reimbursed at the median rate for skilled care  
2 facilities of that type (freestanding or ~~hospital-based~~ hospital based) for the first three (3) full  
3 years of operation; and

4 (11) A facility adding new beds will have its rates for the three (3) full years following  
5 the addition of the beds subjected to an additional reimbursement limitation. This limitation  
6 will apply beginning with the first rate setting period which uses a cost report that includes  
7 the date when the beds were added. The facility's rate will be limited to the bed-weighted  
8 average of two (2) rates: the facility's rate in effect immediately prior to the rate first subject  
9 to the limitation and the median rate for skilled care facilities of that type (freestanding or  
10 ~~hospital-based~~ hospital based) at the time the beds were added; and

11 (12) A facility acquired prior to the end of that facility's fiscal year will be reimbursed  
12 at the rate then in effect for that facility until the next cost report can be used for rate setting.  
13 If the department determines that the facility is operationally or financially unstable, the  
14 department may negotiate a reimbursement rate different than the rate then in effect for that  
15 facility; and

16 (13) If the department determines that a facility is located in an ~~under-served~~ underserved  
17 area, or addresses an underserved need, the department may negotiate a reimbursement rate  
18 different than the rate then in effect for that facility; and

19 (14) From July 1, 1999, through June 30, 2002, the nursing facility inflation rate plus  
20 one percent (1%) per year shall be added to the costs reported in a facility's cost report for  
21 purposes of setting that facility's rate. The inflation rate to be used effective July 1, 2002,  
22 and the period of its use will be based on negotiations between the department, the state  
23 association(s) representing freestanding skilled care facilities, and the state association(s)  
24 representing ~~hospital-based~~ hospital based skilled care facilities; and

25 (15) To control the growth in the cost limits, the increase in the cost limits shall not  
26 exceed the skilled nursing facility inflation rate established by data resources, inc., or its  
27 successor, plus two percent (2%) per year for the period from July 1, 1999, through June 30,  
28 2002. The maximum rate of growth in the cost limits to be used effective July 1, 2002, and the  
29 period of its use will be based on negotiations between the department, the state association(s)  
30 representing freestanding skilled care facilities, and the state association(s) representing  
31 ~~hospital-based~~ hospital based skilled care facilities; and

32 (16) To control declines in the cost limits, the cost limits for the period from July 1,  
33 1999, through June 30, 2002, shall not be lower than the respective cost limits effective July 1,  
34 1999. The minimum cost limits to be used effective July 1, 2002, and the period of ~~its~~ their  
35 use will be based on negotiations between the department, the state association(s) representing  
36 freestanding skilled care facilities, and the state association(s) representing ~~hospital-based~~  
37 hospital based skilled care facilities; and

38 (17) Rates shall be ~~re-based~~ rebased annually. Rate setting shall be prospective with  
39 new rates effective July 1 of each year, using the principles applying to skilled care facilities  
40 set forth in this chapter and the rules promulgated pursuant to this chapter. There will be no  
41 settlement between actual costs incurred during the rate year and the rate itself. Rates will be  
42 established using the most recent audited cost report trended forward to the rate year. Rates  
43 for skilled care facilities with unaudited cost reports will be interim rates established by the  
44 department until a rate is calculated based on an audited cost report. The draft audit of a cost  
45 report submitted by a facility shall be issued by the department no later than five (5) months

1 from the date all information required for completion of the audit is filed with the department;  
2 and

3 (18) Changes of more than fifty cents (50¢) per patient day in allowable costs resulting  
4 from federal or state law or rule changes shall be treated as costs separate from the cost  
5 limitations until such time as they become part of the data used for calculating the cost limits  
6 and in cost reports used for rate setting; and

7 (19) If a review of the data submitted by a facility reveals errors that result in an incorrect  
8 case mix index, the department may retroactively adjust the facility's rate and pay the facility  
9 any amount by which the facility was underpaid or recoup from the facility any amount by  
10 which the facility was overpaid; and

11 (20) The rates established under the principles set forth in this section shall be phased  
12 in using a combination of the reimbursement methodology in effect as of state fiscal year  
13 1999 and the principles set forth in this section and in rules based on negotiations between  
14 the department, the state association(s) representing freestanding skilled care facilities, and the  
15 state association(s) representing ~~hospital-based~~ hospital based skilled care facilities. Effective  
16 July 1, 2001, the ~~phase-in~~ phase in provisions will no longer apply and the department shall pay  
17 rates solely based on the principles set forth in this section and the applicable rules.

18 SECTION 2. That Section 56-113, Idaho Code, be, and the same is hereby amended to  
19 read as follows:

20 56-113. INTERMEDIATE CARE FACILITIES FOR THE MENTALLY  
21 RETARDED. (1) Services provided by intermediate care facilities for the mentally retarded,  
22 with the exception of state operated facilities, shall be paid in accordance with the provisions of  
23 this section, and not as provided in any other section of this chapter, unless otherwise provided  
24 in this section. State operated facilities shall be reimbursed costs based on medicare reasonable  
25 cost provisions.

26 (2) Except as otherwise provided in this section, intermediate care facilities for the  
27 mentally retarded shall remain at the rate paid in state fiscal year 2009 through June 30, 2010.  
28 Thereafter, intermediate care facilities for the mentally retarded shall be reimbursed based on  
29 a prospective rate system without retrospective settlement effective October 1, 1996. In no  
30 event, shall payments to this class of facility exceed, in the aggregate, the amount which would  
31 be reimbursed using medicare cost reimbursement methods as defined in the medicare provider  
32 reimbursement manual (HCFA - pub. 15).

33 (3) The prospective rate shall consist of the following components:

34 (a) A component for reasonable property costs which shall be computed using the  
35 property rental rate methodology set forth in section 56-108, Idaho Code, with the  
36 exceptions that the base rate shall exclude major moveable equipment and grandfathered  
37 rates will not apply. The initial base rate shall be eight dollars and ninety-four cents  
38 (\$8.94) for facilities that accommodate residents in wheelchairs and five dollars and  
39 eighty-one cents (\$5.81) for facilities that cannot accommodate residents in wheelchairs.  
40 The rates shall be adjusted annually as provided in section 56-108, Idaho Code; and

41 (b) A component for forecasted reasonable day treatment costs which shall be subject to  
42 a per patient day limit as provided in rule; and

43 (c) A component for all other allowable costs as determined in accordance with  
44 department rules which shall be subject to a limitation based on a percentage of the

1 forecasted median for such costs of intermediate care facilities for the mentally retarded,  
2 excluding state operated facilities; and

3 (d) A component that provides an efficiency increment payment of twenty cents (~~20¢~~)  
4 for each one dollar (\$1.00) per patient day that the facility is under the limit described in  
5 subsection (3)(c) of this section up to a maximum payment of three dollars (\$3.00) per  
6 patient day.

7 (4) The director may require retrospective settlement as provided by rule in limited  
8 circumstances including, but not limited to:

9 (a) The facility fails to meet quality of care standards; or

10 (b) The facility is new or operated by a new provider, until such time as a prospective  
11 rate is set; or

12 (c) The prospective rate resulted from fraud, abuse or error.

13 (5) The director shall have authority to provide by rule, exceptions to the limitations  
14 described in subsection (3) of this section.

15 (6) The director shall promulgate the rules necessary to carry out the provisions of this  
16 section.

17 SECTION 3. That Section 56-136, Idaho Code, be, and the same is hereby amended to  
18 read as follows:

19 56-136. PHYSICIAN AND DENTIST REIMBURSEMENT. (1) The rate of  
20 reimbursement for all medicaid-covered physician and dentist services rendered to medicaid  
21 recipients shall remain at the rate paid in state fiscal year 2009 through June 30, 2010.  
22 Thereafter, the reimbursement rate for all medicaid-covered physician and dentist services  
23 rendered to medicaid recipients shall be adjusted each fiscal year. Each fiscal year adjustment  
24 shall be determined by the director and shall equal the year over year inflation rate forecasted  
25 as of the midpoint of the fiscal year by the all item, goods and services index in the pacific  
26 northwest as published by ~~data resources incorporated~~ global insights, inc., or its successor.  
27 Such forecast index shall be the last published forecast prior to the start of the fiscal year.  
28 Provided however, an adjustment may exceed the index rate cited in this section at the  
29 discretion of the legislature.

30 (2) Actual payments made by the director to each physician and dentist shall not exceed  
31 the usual and customary charges made to private pay patients.

32 (3) For the purposes of this section:

33 (a) "~~Physician~~Physician" means a person licensed to practice medicine pursuant to chapter  
34 18, title 54, Idaho Code.

35 (b) "Dentist" means a person licensed to practice dentistry pursuant to chapter 9, title 54,  
36 Idaho Code.

37 (4) The amount to be paid under the provisions of this section shall in no event exceed  
38 any limitations imposed by federal law or regulation.

39 SECTION 4. That Section 56-255, Idaho Code, be, and the same is hereby amended to  
40 read as follows:

41 56-255. MEDICAL ASSISTANCE PROGRAM – SERVICES TO BE PROVIDED. (1)  
42 The department may make payments for the following services furnished by providers  
43 to participants who are determined to be eligible on the dates on which the services

1 were provided. Any service under this section shall be reimbursed only when medically  
 2 necessary and in accordance with federal law and regulation, Idaho law and department rule.  
 3 Notwithstanding any other provision of this chapter, medical assistance includes the following  
 4 benefits specific to the eligibility categories established in section 56-254(1), (2) and (3), Idaho  
 5 Code, as well as a list of benefits to which all Idaho medicaid participants are entitled, defined  
 6 in subsection (5) of this section.

7 (2) Specific health benefits and limitations for low-income children and working-age  
 8 adults with no special health needs include:

- 9 (a) All services described in subsection (5) of this section;  
 10 (b) Early and periodic screening, diagnosis and treatment services for individuals under  
 11 age twenty-one (21) years, and treatment of conditions found; and  
 12 (c) Cost-sharing required of participants. Participants in the low-income children and  
 13 working-age adult group are subject to the following premium payments, as stated in  
 14 department rules:

15 (i) Participants with family incomes equal to or less than one hundred thirty-three  
 16 percent (133%) of the federal poverty guideline are not required to pay premiums;  
 17 and

18 (ii) Participants with family incomes above one hundred thirty-three percent  
 19 (133%) of the federal poverty guideline will be required to pay premiums in  
 20 accordance with department rule.

21 (3) Specific health benefits for persons with disabilities or special health needs include:

- 22 (a) All services described in subsection (5) of this section;  
 23 (b) Early and periodic screening, diagnosis and treatment services for individuals under  
 24 age twenty-one (21) years, and treatment of conditions found;  
 25 (c) Case management services as defined in accordance with section 1905(a)(19) or  
 26 section 1915(g) of the social security act; and  
 27 (d) Mental health services, including:

28 (i) Inpatient psychiatric facility services whether in a hospital, or for persons  
 29 under age twenty-two (22) years in a freestanding psychiatric facility, as permitted  
 30 by federal law, in excess of those limits in department rules on inpatient  
 31 psychiatric facility services provided under subsection (5) of this section;

32 (ii) Outpatient mental health services in excess of those limits in department rules  
 33 on outpatient mental health services provided under subsection (5) of this section;  
 34 and

35 (iii) Psychosocial rehabilitation for reduction of mental disability for children  
 36 under the age of eighteen (18) years with a serious emotional disturbance (SED)  
 37 and for severely and persistently mentally ill adults, aged eighteen (18) years or  
 38 older, with severe and persistent mental illness;

39 (e) Long-term care services, including:

40 (i) Nursing facility services, other than services in an institution for mental  
 41 diseases, subject to participant cost-sharing;

42 (ii) Home-based and community-based services, subject to federal approval,  
 43 provided to individuals who require nursing facility level of care who, without  
 44 home-based and community-based services, would require institutionalization.  
 45 These services will include community supports, including an option for

- 1 self-determination, which will enable individuals to have greater freedom to  
 2 manage their own care; and
- 3 (iii) Personal care services in a participant's home, prescribed in accordance with  
 4 a plan of treatment and provided by a qualified person under supervision of a  
 5 registered nurse;
- 6 (f) Services for persons with developmental disabilities, including:
- 7 (i) Intermediate care facility services, other than such services in an institution  
 8 for mental diseases, for persons determined in accordance with section 1902(a)(31)  
 9 of the social security act to be in need of such care, including such services in a  
 10 public institution, or distinct part thereof, for the mentally retarded or persons with  
 11 related conditions;
- 12 (ii) Home-based and community-based services, subject to federal approval,  
 13 provided to individuals who require an intermediate care facility for the mentally  
 14 retarded (ICF/MR) level of care who, without home-based and community-based  
 15 services, would require institutionalization. These services will include  
 16 community supports, including an option for self-determination, which will enable  
 17 individuals to have greater freedom to manage their own care; and
- 18 (iii) Developmental services. The department shall pay for rehabilitative services,  
 19 including medical or remedial services provided by a facility that has entered  
 20 into a provider agreement with the department and is certified as a developmental  
 21 disabilities agency by the department;
- 22 (g) Home health services, including:
- 23 (i) Intermittent or part-time nursing services provided by a home health agency  
 24 or by a registered nurse when no home health agency exists in the area;
- 25 (ii) Home health aide services provided by a home health agency; and
- 26 (iii) Physical therapy, occupational therapy or speech pathology and audiology  
 27 services provided by a home health agency or medical rehabilitation facility;
- 28 (h) Hospice care in accordance with section 1905(o) of the social security act;
- 29 (i) Specialized medical equipment and supplies; ~~and~~
- 30 (j) Medicare cost-sharing, including:
- 31 (i) Medicare cost-sharing for qualified medicare beneficiaries described in section  
 32 1905(p) of the social security act;
- 33 (ii) Medicare part A premiums for qualified disabled and working individuals  
 34 described in section 1902(a)(10)(E)(ii) of the social security act;
- 35 (iii) Medicare part B premiums for specified low-income medicare beneficiaries  
 36 described in section 1902(a)(10)(E)(iii) of the social security act; and
- 37 (iv) Medicare part B premiums for qualifying individuals described in section  
 38 1902(a)(10)(E)(iv) and subject to section 1933 of the social security act; and
- 39 (k) Nonemergency medical transportation.
- 40 (4) Specific health benefits for persons over twenty-one (21) years of age who have  
 41 medicare and medicaid coverage include:
- 42 (a) All services described in subsection (5) of this section, other than if provided under  
 43 the federal medicare program;
- 44 (b) All services described in subsection (3) of this section, other than if provided under  
 45 the federal medicare program; ~~and~~
- 46 (c) Other services that supplement medicare coverage; and

1 (d) Nonemergency medical transportation.

2 (5) Benefits for all medicaid participants, unless specifically limited in subsection (2), (3)  
3 or (4) of this section include the following:

4 (a) Health care coverage including, but not limited to, basic inpatient and outpatient  
5 medical services, and including:

6 (i) Physicians' services, whether furnished in the office, the patient's home, a  
7 hospital, a nursing facility or elsewhere;

8 (ii) Services provided by a physician or other licensed practitioner to prevent  
9 disease, disability and other health conditions or their progressions, to prolong life,  
10 or to promote physical or mental health; and

11 (iii) Hospital care, including:

12 1. Inpatient hospital services other than those services provided in an  
13 institution for mental diseases;

14 2. Outpatient hospital services; and

15 3. Emergency hospital services;

16 (iv) Laboratory and x-ray services;

17 (v) Prescribed drugs;

18 (vi) Family planning services and supplies for individuals of child-bearing age;

19 (vii) Certified pediatric or family nurse practitioners' services;

20 (viii) Emergency medical transportation;

21 (ix) Mental health services, including:

22 1. Outpatient mental health services that are appropriate, within limits  
23 stated in department rules; and

24 2. Inpatient psychiatric facility services within limits stated in department  
25 rules;

26 (x) Medical supplies, equipment, and appliances suitable for use in the home;  
27 and

28 (xi) Physical therapy and related services;

29 (b) Primary care case management;

30 (c) Dental services, and medical and surgical services furnished by a dentist in  
31 accordance with section 1905(a)(5)(B) of the social security act;

32 (d) Medical care and any other type of remedial care recognized under Idaho law,  
33 furnished by licensed practitioners within the scope of their practice as defined by Idaho  
34 law, including:

35 (i) Podiatrists' services;

36 (ii) Optometrists' services;

37 (iii) Chiropractors' services; and

38 (iv) Other practitioners' services, in accordance with department rules;

39 (e) Services for individuals with speech, hearing and language disorders, provided by or  
40 under the supervision of a speech pathologist or audiologist;

41 (f) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an  
42 optometrist;

43 (g) Services provided by essential providers, including:

44 (i) Rural health clinic services and other ambulatory services furnished by a rural  
45 health clinic in accordance with section 1905(l)(1) of the social security act;

1 (ii) Federally qualified health center (FQHC) services and other ambulatory  
 2 services that are covered under the plan and furnished by an FQHC in accordance  
 3 with section 1905(l)(2) of the social security act;

4 (iii) Indian health services;

5 (iv) District health departments; and

6 (v) The family medicine residency of Idaho and the Idaho state university family  
 7 medicine residency;

8 (h) Any other medical care and any other type of remedial care recognized under state  
 9 law, specified by the secretary of the federal department of health and human services;

10 and

11 ~~(i) Nonemergency medical transportation; and~~

12 ~~(j)~~ Physician, hospital or other services deemed experimental are excluded from  
 13 coverage. The director may allow coverage of procedures or services deemed  
 14 investigational if the procedures or services are as cost-effective as traditional, standard  
 15 treatments.

16 SECTION 5. That Section 56-1401, Idaho Code, be, and the same is hereby amended to  
 17 read as follows:

18 56-1401. SHORT TITLE – LEGISLATIVE INTENT. (1) This chapter shall be known  
 19 and may be cited as the "Idaho Hospital Assessment Act."

20 (2) It is the intent of the legislature to encourage the maximization of financial resources  
 21 eligible and available for medicaid services by establishing a fund within the Idaho department  
 22 of health and welfare to receive private hospital assessments to use in securing federal matching  
 23 funds under federally prescribed upper payment limit and disproportionate share hospital  
 24 programs available through the state medicaid plan.

25 SECTION 6. That Section 56-1402, Idaho Code, be, and the same is hereby amended to  
 26 read as follows:

27 56-1402. DEFINITIONS. As used in this chapter:

28 (1) "Department" means the department of health and welfare.

29 (2) "Disproportionate share hospital" means a hospital that serves a disproportionate  
 30 share of medicaid low-income patients as compared to other hospitals as determined by  
 31 department rule.

32 (3) "Governmental entity" means and includes the state and its political subdivisions.

33 ~~(24)~~ "Hospital" is as defined in section 39-1301(a), Idaho Code.

34 ~~(35)~~ "Political subdivision" means a county, city, municipal corporation or hospital taxing  
 35 district and, as used in this chapter, shall include state licensed hospitals established by counties  
 36 pursuant to chapter 36, title 31, Idaho Code, or jointly by cities and counties pursuant to  
 37 chapter 37, title 31, Idaho Code.

38 ~~(46)~~ "Private hospital" means a hospital that is not owned by a governmental entity.

39 ~~(57)~~ "Upper payment limit" means a limitation established by federal regulations, 42  
 40 CFR 447.272 and 42 CFR 447.321, that disallows federal matching funds when state medicaid  
 41 agencies pay certain classes of hospitals an aggregate amount for inpatient and outpatient  
 42 hospital services that would exceed the amount that would be paid for the same services  
 43 furnished by that class of hospitals under medicare payment principles.

1 SECTION 7. That Section 56-1404, Idaho Code, be, and the same is hereby amended to  
2 read as follows:

3 56-1404. ASSESSMENTS. (1) All hospitals, except those exempted under section  
4 56-1408, Idaho Code, shall make payments to the fund in accordance with this chapter. Subject  
5 to section 56-1410, Idaho Code, an annual assessment on both inpatient and outpatient services  
6 is determined for each qualifying hospital for state fiscal years 2009, 2010 and 2011, in an  
7 amount calculated by multiplying the rate, as set forth in subsections (2)(b) and (3)(b) of this  
8 section, by the assessment base, as set forth in subsection (45) of this section.

9 (2) (a) The department shall calculate the private hospital upper payment limit gap for  
10 both inpatient and outpatient services. The upper payment limit gap is the difference  
11 between the maximum allowable payments eligible for federal match, less medicaid  
12 payments not financed using hospital assessment funds. The upper payment limit gap  
13 shall be calculated separately for hospital inpatient and outpatient services. Medicaid  
14 disproportionate share payments shall be excluded from the calculation.

15 ~~(3)(b)~~ The department shall calculate the upper payment limit assessment rate for state  
16 fiscal years 2009, 2010 and 2011 to be the percentage that, when multiplied by the  
17 assessment base as defined in subsection (45) of this section, equals the upper payment  
18 limit gap determined in subsection paragraph (2a) of this subsection, ~~but is not greater~~  
19 ~~than one and one half percent (1.5%).~~

20 (3) (a) The department shall calculate the disproportionate share allotment amount to be  
21 paid to private in-state hospitals.

22 (b) The department shall calculate the disproportionate share assessment rate for private  
23 in-state hospitals to be the percentage that, when multiplied by the assessment base as  
24 defined in subsection (5) of this section, equals the amount of state funding necessary to  
25 pay the private in-state hospital disproportionate share allotment determined in paragraph  
26 (a) of this subsection.

27 (4) For private in-state hospitals, the assessments calculated pursuant to subsections  
28 (2) and (3) of this section shall not be greater than two and one-half percent (2.5%) of the  
29 assessment base as defined in subsection (5) of this section.

30 (5) The assessment base shall be the hospital's net patient revenue for the applicable  
31 period. "Net patient revenue" for state fiscal year 2009 shall be determined using the most  
32 recent data available from each hospital's fiscal year 2004 medicare cost report on file with  
33 the department on June 30, 2008, without regard to any subsequent adjustments or changes to  
34 such data. Net patient revenue for state fiscal year 2010 shall be determined using the most  
35 recent data available for each hospital's fiscal year 2005 medicare cost report on file with the  
36 department on June 30, 2009, without regard to any subsequent adjustments or changes to  
37 such data. Net patient revenue for state fiscal year 2011 shall be determined using the most  
38 recent data available from each hospital's fiscal year 2006 medicare cost report on file with the  
39 department on June 30, 2010, without regard to any subsequent adjustments or changes to such  
40 data.

41 SECTION 8. That Section 56-1406, Idaho Code, be, and the same is hereby amended to  
42 read as follows:

1           56-1406. INPATIENT AND OUTPATIENT ADJUSTMENT PAYMENTS. All  
 2 hospitals, except those exempted under section 56-1408, Idaho Code, shall be eligible for  
 3 inpatient and outpatient adjustments as follows:

4           (1) For state fiscal year 2009, the inpatient upper payment limit gap for private hospitals  
 5 shall be divided by medicaid inpatient days for the same hospitals from calendar year 2007 to  
 6 establish an average per diem adjustment rate. Each hospital shall receive an annual payment  
 7 that is equal to the average per diem adjustment rate multiplied by the hospital's calendar year  
 8 2007 medicaid inpatient days. For purposes of this section, "hospital medicaid inpatient days"  
 9 are days of inpatient hospitalization paid for by the Idaho medical assistance program for the  
 10 applicable calendar year. For fiscal year 2010, calendar year 2008 inpatient hospital medicaid  
 11 days shall be utilized to determine the hospital inpatient adjustment payment. For state fiscal  
 12 year 2011, calendar year 2009 hospital medicaid inpatient days shall be utilized to determine  
 13 the hospital inpatient adjustment payment. In the event that either the inpatient upper payment  
 14 limit gap for private hospitals or the available hospital assessment funding is lower than  
 15 anticipated, the department shall apply an across-the-board factor such that the inpatient  
 16 payment adjustments are maximized, financed entirely from hospital assessment funding, and  
 17 do not exceed the Idaho inpatient upper payment limit for private hospitals. Payments shall be  
 18 made no later than ~~seven~~ thirty (730) days after the ~~due date for~~ receipt of the last deposit of  
 19 the hospital assessment required in section 56-1404, Idaho Code.

20           (2) For state fiscal year 2009, the outpatient upper payment limit gap for private hospitals  
 21 shall be divided by medicaid outpatient hospital reimbursement for the same hospitals from  
 22 calendar year 2007 to establish an average percentage adjustment rate. Each hospital, except  
 23 those exempt under section 56-1408, Idaho Code, shall receive an annual payment that is  
 24 equal to the average percentage adjustment rate multiplied by the hospital's calendar year 2007  
 25 hospital medicaid outpatient reimbursement. For purposes of this section, "hospital outpatient  
 26 reimbursement" is reimbursement for hospital outpatient services paid for by the Idaho medical  
 27 assistance program for the applicable calendar year. For state fiscal year 2010, calendar year  
 28 2008 hospital medicaid outpatient reimbursement shall be utilized to determine the outpatient  
 29 hospital adjustment payment. For state fiscal year 2011, calendar year 2009 hospital medicaid  
 30 outpatient reimbursement shall be utilized to determine the outpatient hospital adjustment  
 31 payment. In the event that either the outpatient upper payment limit gap for private hospitals  
 32 or the available hospital assessment funding is lower than anticipated, the department shall  
 33 apply an across-the-board factor, such that outpatient adjustment payments are maximized,  
 34 financed entirely from hospital assessment funding, and do not exceed the Idaho outpatient  
 35 upper payment limit for private hospitals. Payments shall be made no later than ~~seven~~ thirty  
 36 (730) days after the ~~due date for~~ receipt of the last deposit of the hospital assessments required  
 37 in section ~~546~~-1404, Idaho Code.

38           SECTION 9. That Section 56-1410, Idaho Code, be, and the same is hereby amended to  
 39 read as follows:

40           56-1410. APPLICABILITY. (1) The assessment required by section 56-1404, Idaho  
 41 Code, shall not take effect or shall cease to be imposed, and any moneys remaining in the fund  
 42 shall be refunded to hospitals in proportion to the amounts paid by such hospitals if:

43           (a) The ~~appropriation for each state fiscal year 2009, 2010 and 2011 from the general~~  
 44 ~~fund for hospital payments under~~ created in section 56-1403, Idaho Code, is used to

1 ~~replace moneys appropriated to the Idaho medical assistance program is less than that~~  
2 ~~for fiscal year 2008 by the legislature; or~~

3 ~~(b) The department makes changes in its rules that reduce the hospital inpatient or~~  
4 ~~outpatient payment rates, including adjustment payment rates, in effect on January 1,~~  
5 ~~2008; or~~

6 ~~(c)~~ The payments to hospitals required under section 56-1403(3), Idaho Code, are  
7 changed or are not eligible for federal matching funds under the Idaho medical assistance  
8 program.

9 (2) The assessment required by section 56-1404, Idaho Code, shall not take effect  
10 or shall cease to be required if the assessment is not approved or is determined to be  
11 impermissible under title XIX of the social security act. Moneys in the fund derived from  
12 assessments required prior thereto shall be distributed in accordance with section 56-1403(3),  
13 Idaho Code, to the extent federal matching funds are not reduced due to the impermissibility of  
14 the assessments, and any remaining moneys shall be refunded to hospitals in proportion to the  
15 amounts paid by such hospitals.

16 SECTION 10. An emergency existing therefor, which emergency is hereby declared to  
17 exist, Section 4 of this act shall be in full force and effect on and after passage and approval,  
18 and retroactively to April 1, 2009.