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 16.03.09 - Medicaid Basic Plan Benefits (Docket No. 16-0309-1003).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the co-chairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative Services. The final date to call a meeting on the enclosed rules is no later than 10-22-10. If a meeting is called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis from Legislative Services. The final date to hold a meeting on the enclosed rules is 11-22-10.

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 334-4845, or send a written request to the address or FAX number indicated on the memorandum attached.

Legislative Services Office
Idaho State Legislature

Serving Idaho's Citizen Legislature

Jeff Youtz
Director

MEMORANDUM

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

FROM: Research & Legislation Staff - Paige Alan Parker PAP

DATE: October 4, 2010

SUBJECT: Department of Health and Welfare - IDAPA 16.03.09 - Medicaid Basic Plan Benefits, (Docket No. 16-0309-1003) (Temporary and Proposed)

By this Temporary and Proposed Docket No. 16-0309-1003 (hereinafter "proposed rule"), the Department of Health and Welfare amends IDAPA 16.03.09 dealing with the Medicaid Basic Plan of Benefits. The Governor's justification for the temporary rule is to comply with deadlines in amendments to governing law or federal programs. The temporary rule became effective on July 1, 2010.

The Department states that the purpose of the proposed rule is to implement the legislative intent of HB 656 (2010) and HB 708 (2010), as well as the Medicare Modernization Act (2003), section 1001(d). Specific changes identified by the Department are: change in the definition of "Medicaid inpatient cost limits," pursuant to HB 656; revision of disproportionate share hospital (DSH) reporting requirements, pursuant to the Medicare Modernization Act; clarification of the definition of "uninsured patient costs," pursuant to the Medicare Modernization Act; and a pharmacy cost survey, pursuant to HB 708.

According to the Department, the proposed rule is authorized by: sections 56-202(b), 56-203(g), 56-203(i) and 56-250 through 56-257, Idaho Code; HB 656 (2010); HB 708 (2010); the Medicare Modernization Act (2003), section 1001(d); and 42 CFR Part 455, subpart D.

Section 56-202(b), Idaho Code, provides the Department with general and broad rulemaking authority. Section 56-203(7) [formerly subsection (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(9) [formerly subsection (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 temporary and proposed rules.

HB 656 (2010) amended the Idaho Hospital Assessment Act, sections 56-1401, et seq., Idaho Code. That bill provided one year (FY 2011) changes to the Act to maximize reimbursement for allowable costs and to assess private hospitals to maintain adequate state trustee and benefit funds. HB 708 (2010) made amendments to Idaho's public assistance law. The Statement of Purpose for that bill stated that it is to contain Medicaid costs by reducing reimbursement and cutting incentives that are unaffordable in the current economic environment and by requiring pharmacies to participate in cost surveys in order to obtain accurate and current prices. That statement provided that pharmacy required participation in cost surveys will allow Medicaid to expand the use of its State Maximum Allowed Cost (SMAC) methodology that is projected to result in reduced program costs.

Section 1001(d) of the Medicare Modernization Act amended the United States Code to require states, as a condition of receiving a payment under the Medicaid law, to submit an annual report identifying each DSH that received a payment adjustment for the preceding fiscal year and the amount of the payment adjustment and to submit an independent audit verifying specified items. 455 CFR subpart D provides the regulations on the independent certified audit of state DSH payment adjustments.

According to the Department, no fee or charge is imposed by the proposed rule. The Department states that the proposed rule should have a positive fiscal effect in a General Fund cost reduction of $1.67 million and a total state and federal fund cost reduction of $8 million.

According to the Department, negotiated rulemaking was not conducted because the changes are to implement legislative intent and the Medicare Modernization Act. The Department states that a public hearing will be held if requested in writing by 25 persons, a political subdivision or an agency. All written comments must be delivered to the Department on or before September 22, 2010.

ANALYSIS

One new definition and three definition modifications are presented in the proposed rule's section on inpatient hospital services definitions. Section 400. New is "critical access hospitals (CAH)," defined as a rural hospital with 25 or less beds as set forth in 42 CFR section 485.620. "Medicaid utilization rate (MUR)" has been modified to delete "Medicaid swing bed days" from

inclusion from what is meant by "inpatient days." For inpatient services on and after July 1, 2010, "principal year" is the Medicare cost report period used to prepare the Medicaid cost settlement. An inpatient with insurance but no covered benefit for the particular medically necessary service, procedure or treatment provided is no longer considered "uninsured patient costs" under the proposed rule.

Medicaid operating and capital and medical education costs are no longer part of a mandatory review by the Department upon request by a hospital. Under the deleted provisions, all hospitals were guaranteed at least 80% of their total allowable Medicaid operating and capital and medical education costs upon final settlement, excluding DSH payments. Section 405.03.

The proposed rule provides for the collection of overpayments and redistribution of DHS payments to the extent that audit findings demonstrate that the payments exceed the documented hospital specific cost limits. This collection and redistribution is to begin in federal fiscal year 2011. Under the proposed rule, the disproportionate share payments must not exceed the DSH state allotment, unless required by federal law. The Department is not obligated to use state Medicaid funds to pay more than the state Medicaid percentage of DSH payments due a provider. If there is evidence of fraud, the provider will be referred to the Medicaid Fraud Unit of the Idaho Attorney General's Office. Section 405.09.g.

Reimbursement to pharmacies for prescription drugs is pursuant to the lowest of four options. One option, the estimated acquisition cost as established by the Department following negotiations with Idaho pharmacy representatives, has had the inclusion of a "reasonable operating margin" deleted from its factors. Section 665.02.d.iii.

Finally, the proposed rule provides for periodic state cost surveys to obtain the most accurate pharmacy drug acquisition costs in establishing a pharmacy reimbursement fee schedule. Pharmacies participating in Medicaid are required to disclose the net costs of all drugs of any special discounts or allowances. Section 665.03.

SUMMARY

The Department's proposed rule appears to the authorized under sections 56-202(b), 56-303(7) and (9), and 56-253(8), Idaho Code.

cc: Department of Health and Welfare - Tamara Prisock and Lourie Neal

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1003

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2010.

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 House Bills 656 and 708 passed by the 2010 legislature; the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also known as the Medicare Modernization Act), Section 1001(d); and 42 CFR Part 455, Subpart D.

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 September 15, 2010.

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:

Rules changes are being made in these rules to implement the legislative intent in House Bills 656 and 708 passed by the 2010 legislature, as well as the Medicare Modernization Act, Section 1001(d). Rule changes for this docket include:

1. Change in definition for Medicaid Inpatient Cost Limits to clarify the “beginning of the principal year” (H0656);
2. Revision of reporting requirements for DSH (Section 1001(d));
3. Clarification to the definition of “uninsured patient costs” in DSH requirements (Section 1001(d)); and
4. Pharmacy cost survey (H0708).

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate in order to comply with deadlines in amendments to governing law or federal programs.

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: N/A

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

Changes related to the pharmacy cost survey will result in a cost reduction of $1.67 million to the state general funds. The total cost reduction for both state and federal funds is $8 million. There is no anticipated fiscal impact to the state general fund related to the other changes being made in this docket.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the changes are to implement the legislative intent in H0656 and H0708 passed by the 2010 legislature, and to implement Section 1001(d) of the Medicare Modernization Act.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Lourie Neal at (208) 287-1162.

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 September 22, 2010.

DATED this 17th day of August, 2010.

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

THE FOLLOWING IS THE TEMPORARY RULE & PROPOSED TEXT FOR DOCKET NO. 16-0309-1003

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. **Critical Access Hospitals (CAH)**. A rural hospital with twenty five (25) or less beds as set forth in 42 CFR Section 485.620. (7-1-10)T

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

0910. **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-one and seven-tenths percent (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. (3-29-10)

101. **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)

112. **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)

123. **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)

134. **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)

145. **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)

156. **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)

167. **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)

178. **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)*~~(7-1-10)T

~~18~~9. **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~~20. **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~~1~~1. **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~~2~~2. **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~~3~~3. **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)*~~(7-1-10)T

c. For inpatient services on or after July 1, 2010 , the principal year will be the Medicare cost report period used to prepare the Medicaid cost settlement. (7-1-10)T

23~~4~~4. **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~~5~~5. **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~~6~~6. **Reimbursement Floor Percentage**. The floor calculation for hospitals with more than forty (40) beds is seventy-seven and four-tenths percent (77.4%) of Medicaid costs, and the floor calculation for hospitals with forty (40) or fewer beds is ninety-one and seven-tenths percent (91.7%). (3-29-10)

26~~7~~7. **TEFRA**. TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248. (3-30-07)

27~~8~~8. **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)*~~(7-1-10)T

2~~8~~9. **Upper Payment Limit**. The Upper Payment Limit for hospital services is defined in the Code of Federal Regulations. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

405. INPATIENT HOSPITAL SERVICES - PROVIDER REIMBURSEMENT.
Under the Medicaid provisions of the Social Security Act, in reimbursing hospitals, the Department will pay the lesser of customary hospital charges or the reasonable cost of inpatient services in accordance with the procedures detailed under this Section of rule. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment that would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement. (3-30-07)

01. Exemption of New Hospitals. A hospital that has operated as the type of facility for which it is certified (or the equivalent thereof) under present and previous ownership for less than three (3) full years will be paid in accordance with the Title XVIII principles of reasonable cost reimbursement, including those provisions applicable to new providers for the carryover and recovery of unreimbursed costs, in accordance with 42 CFR Section 413.64. (3-30-07)

02. Medicaid Inpatient Operating Cost Limits. The following describe the determination of inpatient operating cost limits. (3-30-07)

a. Medicaid Cost Limits for Dates of Service Prior to a Current Year. The reimbursable reasonable costs for services rendered prior to the beginning of the principal year, but included as prior period claims in a subsequent period's cost report, will be subject to the same operating cost limits as the claims under settlement. (3-30-07)

b. Application of the Medicaid Cost Limit. In the determination of a hospital's reasonable costs for inpatient services rendered after the effective date of a principal year, a Hospital Inflation Index, computed for each hospital's fiscal year end, will be applied to the operating costs, excluding capital costs and other allowable costs as defined for the principal year and adjusted on a per diem basis for each subsequent year under the Hospital Inflation Index. (3-30-07)

i. Each inpatient routine service cost center, as reported in the finalized principal year end Medicare cost report, will be segregated in the Medicaid cost limit calculation and assigned a share of total Medicaid inpatient ancillary costs. The prorated ancillary costs will be determined by the ratio of each Medicaid routine cost center's reported costs to total Medicaid inpatient routine service costs in the principal year. (3-30-07)

ii. Each routine cost center's total Medicaid routine service costs plus the assigned share of Medicaid inpatient ancillary costs of the principal year will be divided by the related Medicaid patient days to identify the total costs per diem in the principal year. (3-30-07)

(1) The related inpatient routine service cost center's per diem capital and graduate medical education costs plus the prorated share of inpatient ancillary capital costs will be subtracted from the per diem amount identified in Subsection 405.02.b.ii. of this rule to identify each inpatient routine service cost center per diem cost limit in the principal year. (3-30-07)

(2) If a provider did not have any Medicaid inpatient utilization or render any Medicaid inpatient services in an individual inpatient routine service cost center in the fiscal year serving as the principal year, the principal year for only those routine cost centers without utilization in the provider's principal year will be

appropriately calculated using the information available in the next subsequent year in which Medicaid utilization occurred. (3-30-07)

iii. Each routine cost center's cost per diem for the principal year will be multiplied by the Hospital Inflation Index for each subsequent fiscal year. (3-30-07)

iv. The sum of the per diem cost limits for the Medicaid inpatient routine service cost centers of a hospital during the principal year, as adjusted by the Hospital Inflation Index, will be the Medicaid cost limit for operating costs in the current year. (3-30-07)

(1) At the date of final settlement, reimbursement of the Medicaid current year inpatient routine cost centers plus the assigned ancillary costs will be limited to the total per diem operating costs as adjusted for each subsequent fiscal year after the principal year through the current year by the Hospital Inflation Cost Index.(3-30-07)

(2) Providers will be notified of the estimated inflation index periodically or Hospital Inflation Index (CMS Market Basket Index) prior to final settlement only upon written request. (3-30-07)

03. Adjustments to the Medicaid Cost Limit. A hospital's request for review by the Department concerning an adjustment to or exemption from the cost limits imposed under the provisions set forth in Section 405 of this chapter of rules, must be granted under the following circumstances: (3-30-07)

a. Adjustments. Because of Extraordinary Circumstances. Where a provider's costs exceed the Medicaid limit due to extraordinary circumstances beyond the control of the provider, the provider can request an adjustment to the cost limit to the extent the provider proves such higher costs result from the extraordinary circumstances including, but not limited to, increased costs attributable to strikes, fires, earthquake, flood, or similar, unusual occurrences with substantial cost effects. (3-30-07)

b. Reimbursement to Public Hospitals. A Public Hospital that provides services free or at a nominal charge, which is less than, or equal to fifty percent (50%) of its total allowable costs, will be reimbursed at the same rate that would be used if the hospital's charges were equal to, or greater than, its costs. (3-30-07)

c. Adjustment to Cost Limits. A hospital is entitled to a reasonable increase in its Medicaid Cost limits if the hospital shows that its per diem costs of providing services have increased due to increases in case- mix, the adoption of new or changed services, the discontinuation of services or decrease in average length of stay for Medicaid inpatients since the principal year. Any hospital making such showing is entitled to an increase commensurate with the increase in per diem costs. (3-30-07)

i. The Medicaid operating cost limit may be adjusted by multiplying cost limit by the ratio of the current year's Case-Mix Index divided by the principal year's Case-Mix Index. (3-30-07)

ii. The contested case procedure set for forth in IDAPA 16.05.03, “Rules Governing Contested Case Proceedings and Declaratory Rulings,” is available to larger hospitals seeking such adjustments to their Medicaid Cost Limits. (3-30-07)

~~*d. Medicaid Operating and Capital and Medical Education Costs. All hospitals will be guaranteed at least eighty percent (80%) of their total allowable Medicaid Operating and Capital and medical education costs upon final settlement excluding DSH payments.* (3-30-07)~~

~~*i. With the exception of Subsection 405.03.d.ii. of this rule, at the time of final settlement, the allowable Medicaid costs related to each hospital's fiscal year end will be according to the Reimbursement Floor Percentage.* (3-30-07)~~

~~*ii. In the event that CMS informs the Department that total hospital payments under the Inpatient Operating Cost Limits exceed the inpatient Upper Payment Limit, the Department may reduce the guaranteed percentage defined as the Reimbursement Floor Percentage to hospitals.* (3-30-07)~~

~~e~~**d.** Adjustment to the Proration of Ancillary Costs in the principal year. Where the provider asserts that

the proration of ancillary costs does not adequately reflect the total Medicaid cost per diem calculated for the inpatient routine service cost centers in the principal year, the provider may submit a detailed analysis of ancillary services provided to each participant for each type of patient day during each participant's stay during the principal year. The provider will be granted this adjustment only once upon appeal for the first cost reporting year that the limits are in effect. (3-30-07)

04. Payment Procedures. The following procedures are applicable to in-patient hospitals: (3-30-07)

a. The participant's admission and length of stay is subject to preadmission, concurrent and retrospective review by a Quality Improvement Organization (QIO) designated by the Department. QIO review will be governed by provisions of the QIO Idaho Medicaid Provider Manual as amended. If such review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. Failure to obtain a timely QIO review as required by Section 405 of this chapter of rules, and as outlined in the QIO Idaho Medicaid Provider Manual as amended, will result in the QIO conducting a late review. After a QIO review has determined that the hospital stay was medically necessary, Medicaid will assess a late review penalty to the hospital as outlined in Subsection 405.05 of this rule. (3-30-07)

i. All admissions are subject to QIO review to determine if continued stay in inpatient status is medically necessary. A QIO continued stay review is required when the participant's length of stay exceeds the number of days certified by the QIO. If no initial length of stay certification was issued by the QIO, a QIO continued stay review is required when the admission exceeds a number of days as specified by the Department. (3-30-07)

ii. Reimbursement for services originally identified as not medically necessary by the QIO will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, “Rules Governing Contested Case Proceedings and Declaratory Rulings.” (3-30-07)

iii. Absent the Medicaid participant's informed decision to incur services deemed unnecessary by the QIO, or not authorized by the QIO due to the negligence of the provider, no payment for denied services may be obtained from the participant. (3-30-07)

b. In reimbursing licensed hospitals, the Department will pay the lesser of customary hospital charges or the reasonable cost of semi-private rates for in-patient hospital care as set forth in this rule, unless an exception applies as stated in Section 402 of these rules. The upper limits for payment must not exceed the payment which would be determined as reasonable cost using the Title XVIII standards and principles. (3-30-07)

05. Hospital Penalty Schedule. (3-30-07)

a. A request for a preadmission and/or continued stay QIO review that is one (1) day late will result in a penalty of two hundred and sixty dollars ($260), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

b. A request for a preadmission and/or continued stay QIO review that is two (2) days late will result in a penalty of five hundred and twenty dollars ($520), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

c. A request for a preadmission and/or continued stay QIO review that is three (3) days late will result in a penalty of seven hundred and eighty dollars ($780), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

d. A request for a preadmission and/or continued stay QIO review that is four (4) days late will result in a penalty of one thousand and forty dollars ($1,040), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

e. A request for a preadmission and/or continued stay QIO review that is five (5) days late or greater will result in a penalty of one thousand three hundred dollars ($1,300), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

06. AND Reimbursement Rate. Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho nursing facilities for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. ICF/ID rates are excluded from this calculation. (3-30-07)

a. The AND reimbursement rate will be calculated by the Department by March 15 of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year. (3-30-07)

b. Hospitals with an attached nursing facility will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and (3-30-07)

c. The Department will pay the lesser of the established AND rate or a facility's customary hospital charge to private pay patients for an AND. (3-30-07)

07. Reimbursement for Services. Routine services as addressed in Subsection 405.08 of this rule include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in these rules. Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (3-30-07)

08. Hospital Swing-Bed Reimbursement. The Department will pay for nursing facility care in certain rural hospitals. Following approval by the Department, such hospitals may provide service to participants in licensed hospital ("swing") beds who require nursing facility level of care. (3-30-07)

a. Facility Requirements. The Department will approve hospitals for nursing facility care provided to eligible participants under the following conditions: (3-30-07)

i. The Department's Licensure and Certification Section finds the hospital in conformance with the requirements of 42 CFR 482.66 "Special Requirements" for hospital providers of long-term care services ("swingbeds"); and (3-30-07)

ii. The hospital is approved by the Medicare program for the provision of "swing-bed" services; and (3-30-07)

iii. The facility does not have a twenty-four (24) hour nursing waiver granted under 42 CFR 488.54(c); and (3-30-07)

iv. The hospital must not have had a swing-bed approval terminated within the two (2) years previous to application for swing-bed participation; and (3-30-07)

v. The hospital must be licensed for less than one hundred (100) beds as defined by 42 CFR 482.66(a)(1) for swing-bed purposes; and (3-30-07)

vi. Nursing facility services in swing-beds must be rendered in beds used interchangeably to furnish hospital or nursing facility-type services. (3-30-07)

b. Participant Requirements. The Department will reimburse hospitals for participants under the following conditions: (3-30-07)

i. The participant is determined to be entitled to such services in accordance with IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled"; and (3-30-07)

ii. The participant is authorized for payment in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 222.02. (3-30-07)

c. Reimbursement for "Swing-Bed" Patient Days. The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: (3-30-07)

i. Payment rates for routine nursing facility services will be at the weighted average Medicaid rate per patient day paid to hospital-based nursing facility/ICF facilities for routine services furnished during the previous calendar year. ICF/ID facilities' rates are excluded from the calculations. (3-30-07)

ii. The rate will be calculated by the Department by March 15 of each calendar year. The rate will be based on the previous calendar year and effective retroactively for dates of service on or after January 1 of the respective year. (3-30-07)

iii. The weighted average rate for nursing facility swing-bed days will be calculated by dividing total payments for routine services, including patient contribution amounts but excluding miscellaneous financial transactions relating to prior years, by total patient days for each respective level of care occurring in the previous calendar year. (3-30-07)

iv. Routine services include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 225.01. (3-30-07)

v. The Department will pay the lesser of the established rate, the facility's charge, or the facility's charge to private pay patients for "swing-bed" services. (3-30-07)

vi. Reimbursement of ancillary services not included in the nursing facility rates furnished for extended care services will be billed and determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (3-30-07)

vii. The number of swing-bed days that may be reimbursed to a provider in a twelve (12) month period will be limited to the greater of one thousand ninety five (1,095) days which may be prorated over a shorter fiscal period or, fifteen percent (15%) of the product of the average number of available licensed beds in the hospital in the period and the number of days in the fiscal period. (3-30-07)

d. Computation of "Swing-Bed" Patient Contribution. The computation of the patient's contribution of swing-bed payment will be in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 224. (3-30-07)

09. Adjustment for Disproportionate Share Hospitals (DSH). All Idaho hospitals serving a disproportionate share of low income patients must qualify either as a Mandatory DSH or as Deemed DSH to receive a DSH payment. (3-29-10)

a. DSH Survey Requirements. The Department will send each hospital a DSH survey on or before January 31 of each calendar year. The DSH survey must be returned to the Department on or before May 31 of the same calendar year. A hospital will not receive a DSH payment if the survey is not returned by the deadline, unless good cause is determined by the Department. No later than July 15 of each calendar year, the Department must notify each hospital of their calculated DSH payment and notify each hospital of its preliminary calculated distribution amount. A hospital may file an amended survey to complete, correct, or revise the original DSH survey by submitting the amended survey and supporting documentation to the Department no later than thirty (30) days after the notice of the preliminary DSH calculation is mailed to the hospital. The state's annual DSH allotment payment will be made by September 30 of the same calendar year based on the final DSH surveys and Department data. (3-30-07)

b. Mandatory Eligibility. Mandatory Eligibility for DSH status will be provided for hospitals which: (3-30-07)

i. Meet or exceed the disproportionate share threshold as defined in Subsection 400.13 of these rules. (3-30-07)

ii. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services. (3-29-10)

(1) Subsection 405.09.b.ii. of this rule does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or (3-30-07)

(2) Does not offer nonemergency inpatient obstetric services as of December 21, 1987. (3-30-07)

iii. The MUR will not be less than one percent (1%). (3-30-07)

iv. If an Idaho hospital exceeds both disproportionate share thresholds, as described in Subsection 400.13 of these rules, and the criteria of Subsections 405.09.b.ii. and 405.09.b.iii. of this rule are met, the payment adjustment will be the greater of the amounts calculated using the methods identified in Subsections 405.09.b.vi. through 405.09.b.x. of this rule. (3-29-10)

v. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one (1) standard deviation and less than one and one-half (1 1/2) standard deviations above the mean of all Idaho hospitals will receive a DSH payment equal to two percent (2%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

vi. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one and one-half (1 1/2) standard deviations and less than two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

vii. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates exceeding two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

viii. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding twenty-five percent (25%) will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

ix. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to, or exceeding, thirty percent (30%) will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

c. Deemed Disproportionate Share Hospital (DSH). All hospitals in Idaho which have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days, and meet the requirements unrelated to patient day utilization specified in Subsection 405.09.b. of this rule, will be designated a Deemed Disproportionate Share Hospital. The disproportionate share payment to a Deemed DSH hospital will be the greater of: (3-29-10)

i. Five dollars ($5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or (3-30-07)

ii. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the DSH allotment amount, less the Mandatory DSH payment amount, divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals. (3-30-07)

d. Insufficient DSH Allotment Amounts. When the DSH allotment amount is insufficient to make the aggregate amount of DSH payments to each DSH hospital, payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. (3-30-07)

e. DSH Payments Will Not Exceed Costs. A DSH payment will not exceed the costs incurred during the year of furnishing services to individuals who are either eligible for medical assistance under the State Plan or were uninsured for health care services provided during the year. (3-30-07)

i. Payments made to a hospital for services provided to indigent patients by a state or a unit of local government within a state will not be considered a source of third party payment. (3-30-07)

ii. Claims of uninsured costs which increase the maximum amount which a hospital may receive as a DSH payment must be documented. (3-30-07)

f. DSH Will be Calculated on an Annual Basis. A change in a provider's allowable costs as a result of a reopening or appeal will not result in the recomputation of the provider's annual DSH payment. (3-30-07)

g. To the extent that audit findings demonstrate that DSH payments exceed the documented hospital specific cost limits, the Department will collect overpayments and redistribute DSH payments. (7-1-10)T

i. If at any time during an audit the Department discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Department's final audit report regarding that provider, will be referred to the Medicaid Fraud Unit of the Idaho Attorney General's Office. (7-1-10)T

ii. The Department will submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with 42 CFR Part 455, Subpart D, "Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments." (7-1-10)T

iii. Beginning with FFY 2011, if based on the audit of the DSH allotment distribution, the Department determines that there was an overpayment to a provider, the Department will immediately: (7-1-10)T

(1) Recover the overpayment from the provider; and (7-1-10)T

(2) Redistribute the amount in overpayment to providers that had not exceeded the hospital-specific upper payment limit during the period in which the DSH payments were determined. The payments will be subject to hospital-specific upper payment limits. (7-1-10)T

iv. Disproportionate share payments must not exceed the DSH state allotment, except as otherwise required by the Social Security Act. In no event is the Department obligated to use State Medicaid funds to pay more than the State Medicaid percentage of DSH payments due a provider. (7-1-10)T

10. Out-of-State Hospitals. (3-30-07)

a. Cost Settlements for Certain Out-of-State Hospitals. Hospitals not located in the state of Idaho will have a cost settlement computed with the state of Idaho if the following conditions are met: (3-30-07)

i. Total inpatient and outpatient covered charges are more than fifty thousand dollars ($50,000) in the fiscal year; or (3-30-07)

ii. When less than fifty thousand dollars ($50,000) of covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department. (3-30-07)

b. Payment for Hospitals Without Cost Settlement. Those out-of-state hospitals not cost settling with the state will have annually adjusted rates of payment no greater than seventy-five percent (75%) for inpatient covered charges and no greater than eighty percent (80%) of outpatient covered charges or, the Department's established fee schedule for certain outpatient services. These rates represent average inpatient and outpatient reimbursement rates paid to Idaho hospitals. (3-30-07)

11. Institutions for Mental Disease (IMD). Except for individuals under twenty-two (22) years of age which are contracted with the Department under the authority of the Division of Family and Community Services and certified by the Health Care Financing Administration, no services related to inpatient care will be covered when admitted to a freestanding psychiatric hospital. (3-30-07)

12. Audit Function. Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Title XVIII and Medicaid purposes. The Department may elect to perform an audit even

though the Medicare Intermediary does not choose to audit the facility. (3-30-07)

13. Adequacy of Cost Information. Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to participants. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another. (3-30-07)

14. Availability of Records of Hospital Providers. A participating hospital provider of services must make available to the Department in the state in which the facility is licensed, the provider's fiscal and other necessary records for the purpose of determining its ongoing record keeping capability and to ascertain information pertinent to the determination of the proper amount of program payments due the provider. (3-30-07)

15. Interim Cost Settlements. The Department may initiate or a hospital may request an interim cost settlement based on the Medicare cost report as submitted to the Medicare Intermediary. (3-30-07)

a. Cost Report Data. Interim settlement cost report data will be adjusted to reflect Medicaid payments and statistical summary reports sent to providers before the filing deadline. (3-30-07)

b. Hard Copy of Cost Report. Hospitals which request to undergo interim cost settlement with Idaho Medicaid must submit a hard copy of the Medicare cost report to the Department upon filing with the Intermediary. (3-30-07)

c. Limit or Recovery of Payment. The Department may limit a recovery or payment of an interim settlement amount up to twenty-five percent (25%) of the total settlement amount when the cost report information is in dispute. (3-30-07)

16. Notice of Program Reimbursement. Following receipt of the finalized Medicare cost report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider which sets forth the amounts of underpayment or overpayment made to the provider. The notice of the results of the final retroactive adjustment will be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Medicaid program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. Such action of recovery or suspension will continue even after a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments will be made to the settlement amount. (3-30-07)

a. Timing of Notice. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the cost report from the Medicare Intermediary. (3-30-07)

b. Reopening of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three (3) year period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the cost report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement. (3-30-07)

17. Nonappealable Items. The formula for the determination of the Hospital Inflation Index, the principles of reimbursement which define allowable cost, non-Medicaid program issues, interim rates which are in compliance with state and federal rules, and the preliminary adjustments prior to final cost settlement determinations as supported by properly completed cost reports and audits must not be accepted as appealable items. (3-30-07)

18. Interim Reimbursement Rates. The interim reimbursement rates are reasonable and adequate to meet the necessary costs which must be incurred by economically and efficiently operated providers which provide

services in conformity with applicable state and federal laws, rules, and quality and safety standards. (3-30-07)

a. Annual Adjustments. Interim rates will be adjusted at least annually based on the best information available to the Department. The interim rate will reflect the Medicaid Inpatient Operating Cost Limits used to set inpatient rates and the Reimbursement Floor Percentage. (3-30-07)

b. Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (3-30-07)

c. Basis for Adjustments. The Department may make an adjustment based on the Medicare cost report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. If the settlement amount is equal to or greater than ten percent (10%) of the payments received or paid and equal to or greater than one hundred thousand dollars ($100,000), the interim rate will be adjusted to account for half (½) of the difference. (3-30-07)

d. Unadjusted Rate. The Medicaid interim reimbursement rate on file is synonymous with the term unadjusted rate used by other payors. (3-30-07)

19. Audits. All financial reports are subject to audit by Departmental representatives in accordance with Section 305 of these rules. (3-30-07)

20. Interim Reimbursement Rates. The interim reimbursement rates are reasonable and adequate to meet the necessary costs which must be incurred by economically and efficiently operated providers which provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. (3-30-07)

a. Annual Adjustments. Interim rates will be adjusted at least annually based on the best information available to the Department. The interim rate will reflect the Medicaid Inpatient Operating Cost Limits used to set inpatient rates and the Reimbursement Floor Percentage. (3-30-07)

b. Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (3-30-07)

c. Basis for Adjustments. The Department may make an adjustment based on the Medicare cost report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. If the settlement amount is equal to or greater than ten percent (10%) of the payments received or paid and equal to or greater than one hundred thousand dollars ($100,000), the interim rate will be adjusted to account for half (½) of the difference. (3-30-07)

d. Unadjusted Rate. The Medicaid interim reimbursement rate on file is synonymous with the term unadjusted rate used by other payors. (3-30-07)

21. Audits. All financial reports are subject to audit by Departmental representatives in accordance with Section 305 of these rules. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

665. PRESCRIPTION DRUGS: PROVIDER REIMBURSEMENT.

01. Nonpayment of Prescriptions. Prescriptions not filled in accordance with the provisions of Subsection 664.02 of these rules will be subject to nonpayment or recoupment. (3-30-07)

02. Payment Procedures. The following protocol must be followed for proper reimbursement.

(3-30-07)

a. Filing Claims. Pharmacists must file claims electronically with Department-approved software or by submitting the appropriate claim form to the fiscal contractor. Upon request, the contractor will provide pharmacies with a supply of claim forms. The form must include information described in the pharmacy guidelines issued by the Department. (3-30-07)

b. Claim Form Review. Each claim form may be subject to review by a contract claim examiner, a pharmaceutical consultant, or a medical consultant. (3-30-07)

c. Billed Charges. A pharmacy's billed charges are not to exceed the usual and customary charges defined as the lowest charge by the provider to the general public for the same service including advertised specials. (3-30-07)

d. Reimbursement. Reimbursement to pharmacies is limited to the lowest of the following: (3-30-07)

i. Federal Upper Limit (FUL), as established by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services, plus the dispensing fee assigned by the Department; (3-30-07)

ii. State Maximum Allowable Cost (SMAC), as established by the Department, plus the assigned dispensing fee; (3-30-07)

iii. Estimated Acquisition Cost (EAC), as established by the Department following negotiations with representatives of the Idaho pharmacy profession defined as an approximation of the net cost of the drug ~~*and a reasonable operating margin*~~, plus the assigned dispensing fee; or ~~*(3-30-07)*~~(7-1-10)T

iv. The pharmacy's usual and customary charge to the general public as defined in Subsection 665.02.c. of this rule. (3-30-07)

e. Dispensing Fees. Only one (1) dispensing fee per month will be allowed for the dispensing of each maintenance drug to any participant as an outpatient or a resident in a care facility except: (3-30-07)

i. Multiple dispensing of topical and injectable medication when dispensed in manufacturer's original package sizes, unless evidence exists, as determined by the Department, that the quantity dispensed does not relate to the prescriber's order; (3-30-07)

ii. Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by the Department, is dispensed at each filling; (3-30-07)

iii. Multiple dispensing of tablets or capsules if the quantity needed for a thirty-four (34) day supply is excessively large or unduly expensive, in the judgment of the Department; or (3-30-07)

iv. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. (3-30-07)

f. Remittance Advice. Claims are processed by computer, and payments are made directly to the pharmacy or its designated bank through electronic claims transfer. A remittance advice with detailed information of each claim transaction will accompany each payment made by the Department. (3-30-07)

g. Return of Drugs. Drugs dispensed in unit dose packaging as defined by IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," Subsection 156.05, must be returned to the dispensing pharmacy when the participant no longer uses the medication as follows: (3-30-07)

i. A pharmacy provider using unit dose packaging must comply with IDAPA 27.01.01, "Rules of the Idaho State Board of Pharmacy," Subsection 156.05. (3-30-07)

ii. The pharmacy provider that receives the returned drugs must credit the Department the amount billed for the cost of the drug less the dispensing fee. (3-30-07)

iii. The pharmacy provider may receive a fee for acceptance of returned unused drugs. The value of the unused drug being returned must be cost effective as determined by the Department. (3-30-07)

03. Periodic State Cost Surveys. The Department will utilize periodic state cost surveys to obtain the most accurate pharmacy drug acquisition costs in establishing a pharmacy reimbursement fee schedule. Pharmacies participating in the Idaho Medicaid program are required to participate in these periodic state cost surveys by disclosing the costs of all drugs net of any special discounts or allowances. (7-1-10)T