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

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

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1003).

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 10-26-10. 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 11-24-10.

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 6, 2010

SUBJECT: Department of Health and Welfare - IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1003) (Temporary and Proposed)

This temporary and proposed rule docket 16-0310-1003 (hereinafter "proposed rule") represents the Department of Health and Welfare's amendments to chapter 16.03.10 dealing with Medicaid enhanced plan benefits. The Governor's justification for the temporary rule is to comply with deadlines in amendments to governing law or federal programs, which is one of the justifications provided for in section 67-5226(1), Idaho Code. The temporary rule was effective on July 1, 2010.

The Department states that the purpose of the proposed rule is to implement the legislative intent in HB 701 (2010) and HB 708 (2010). Specifically, the proposed rule provides for clarification of nursing facility coverage and limitations, a nursing facility inflation freeze, a nursing facility efficiency incentive, special rate payment offset clarification for nursing facilities, and incentive changes for Intermediate Care Facilities for the Mentally Retarded. Please note that SB 1330 (2010) has changed the terminology from "mentally retarded" to "intellectually disabled" for these Intermediate Care Facilities and has requested that rules promulgated after the effective date of that act use the more modern terminology. Additional cost adjustments for nursing facilities and intermediate care facilities are contained in Docket No. 16-0310-1004, a temporary rule that is not reviewed herein.

According to the Department, the proposed rule is authorized pursuant to sections 56-202(b), 56-203(g) and (i), and 56-250 through 56-257, Idaho Code, HB 701 (2010) and HB 708 (2010).

Mike Nugent, Manager
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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 proposed rule.

HB 701 (2010) is the appropriation for the Department's medical assistance services for the 2011 fiscal year. Section 12 of that appropriation provided legislative intent for a freeze on all price increases, regardless of calculation basis, in all categories with the exception of those increases that are mandated by federal law and provided for in the appropriation for the Medicaid program. Section 13 of that appropriation provided the Department with temporary rulemaking authority to impose requirements for Medicaid programs funded by the General Fund for fiscal year 2011.

HB 708 (2010) amended the law regarding reimbursement rates for nursing home providers for fiscal year 2011, to provide that this rate will only be adjusted if the prevailing hourly rate for comparable positions is less than the rate paid during state fiscal year 2010.

According to the Department, changes related to HB 701 will result in a reduction of $193,000 to the General Fund and total state and federal cost reduction of $965,000, and changes related to HB 708 will result in a reduction of $1.09 million to the General Fund and total state and federal reduction of $5.4 million. Negotiated rulemaking was not conducted because the rule changes are being made to implement legislative intent contained in HB 701 and HB 708. A public hearing would have been held if requested in writing by twenty-five persons, a political subdivision or an agency not later than September 15, 2010. All written comments were to be delivered on or before September 22, 2010.

ANALYSIS

Section 039.01 of the proposed rule deletes reference to an efficiency incentive allowed to low-cost providers in accordance with section 296 of the rule chapter, but does not amend section 296, which provides for such payments, subject to availability of funding. Section 257 of the proposed rule also deletes reference to the efficiency incentive available to freestanding and

hospital-based providers that had inflated per diem indirect care costs less than the indirect per diem cost limit for that type of provider.

The minimum content of care in a nursing facility presents several changes: supervision is clarified to relate to the duration of the patient's stay in the facility, section 225.01.e; common over-the-counter medicines are included in the minimum content of care, section 225.01.g; and incontinent supplies are listed as a medical supply, section 225.01.k.

The provisions regarding the special rate add-on for specialized patient care have been modified. The identified condition upon which the special rate is based must continue for a period of greater than 30 days, rather than two weeks. Section 270.01. Retroactive application of the special rate has been deleted. Section 270.02. The reporting requirements have been changed to specify that a "grossed up" payment for special rates be reported separately. "Gross up" is calculated by dividing the Medicaid incremental revenues by Medicaid days and multiplying the result by total patient days. Section 270.03.

The calculation of the special rate for equipment and non-therapy supplies is at the Medicaid Basic Plan Benefit rate, rather than at invoice cost. Section 270.06.b. The two-step approach in calculating the special rate for ventilator care and tracheostomy care has been modified to require that the additional direct care staff be higher than the amount indicated on the resident's most recent Medicaid resource utilization groups (RUG) score and that non-therapy supplies follow the Medicaid Basic Plan Benefit rate, rather than the invoice cost or rental amount. Section 270.06.c.

The basis for calculating varying levels for one-to-one care has been deleted. The facility may request a special rate for staffing, including one-to-one care, to meet exceptional needs of the resident if the staffing level is higher than the amount indicated on the resident's most recent Medicaid RUG score. The hourly add-on rate for such staffing has been changed from an additional 30 percent of the weighted average hourly rate (WAHR) certified nursing assistant (CNA) wage rate to the WAHR CNA wage rate plus a benefits allowance based on annual cost reporting data. Section 270.06.d.

Since special rates are established on a prospective basis, a "grossed up" amount (calculated by dividing the Medicaid incremental revenue by Medicaid days and multiplying by total patient days) is used to reduce cost when the cost report used to set a prospective rate contains non-unit special rate costs. Section 270.07.

The proposed rule changes the method on which the calculation of the personal assistance agency rate for personal assistance services is made. A 55% supplement component for travel, administration, training, payroll taxes and fringe benefits has been deleted. Instead, for fiscal year 2011, this rate will be adjusted if the prevailing hourly rate for comparable positions is less than the rate paid during fiscal year 2010. Beginning in fiscal year 2011, the amount to be paid for these expenses will be based on a survey to be conducted by the Department of all personal

assistance agencies every five years, provided that 85% of the agencies respond. If an 85% response is not received, the rate will remain at the WAHR rate without the supplemental component. The proposed rule does not state a method for calculating the actual amount of the supplemental component. Section 307.04.

Similarly, the method of calculating the PCS Family Alternate Care Home rates for personal assistance services has also been modified by deleting the adjusted 55% times the WAHR rate supplement to cover travel, administration and training costs, and replacing that formula with a survey conducted every five years. Again, the proposed rule does not state a method for calculating the actual amount of the supplemental component. Section 307.08.

The proposed rule deletes the section dealing with the Intermediate Care Facility for the Intellectually Disabled efficiency increment. Section 625.

SUMMARY

The Department's proposed rule appears to be authorized under sections 56-202(b), 56-203(7) and (9) and 56-253(8), Idaho Code.

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

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1003

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 701 and 708 passed by the 2010 legislature.

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:

Rule changes are being made in these rules to implement the legislative intent in House Bills 701 and 708 passed by the 2010 legislature. Rule changes for this docket include:

1. Clarification of nursing facility coverage and limitations;
2. Nursing facility inflation freeze;
3. Nursing facility efficiency incentive;
4. Nursing facility special rate payment offset clarification; and
5. Incentive changes for Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

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 House Bill 701 will result in a reduction of $193,000 to the state general fund (cost reduction of $965,000 in total funds (state and federal combined)).

Changes related to House Bill 708 will result in a cost reduction of $1.09 million to the state general fund (cost reduction of $5.4 million in total funds (state and federal combined)).

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the changes are being made to implement the legislative intent in H0701 and H0708 passed by the 2010 legislature.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

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

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 22, 2010.

DATED this 13th 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. 16-0310-1003

039. ACCOUNTING TREATMENT.
Generally accepted accounting principles, concepts, and definitions will be used except as otherwise specified. Where alternative treatments are available under GAAP, the acceptable treatment will be the one that most clearly attains program objectives. (3-19-07)

01. Final Payment. A final settlement will be made based on the reasonable cost of services as determined by audit, limited in accordance with other sections of this chapter. ~~*In addition, an efficiency incentive will be allowed to low cost providers in accordance with the provisions of Section 296 of these rules.* *(3-19-07)*~~(7-1-10)T

02. Overpayments. As a matter of policy, recovery of overpayments will be attempted as quickly as possible consistent with the financial integrity of the provider. (3-19-07)

03. Other Actions. Generally, overpayment will result in two (2) circumstances: (3-19-07)

a. If the cost report is not filed, the sum of the following will be due: (3-19-07)

i. All payments included in the period covered by the missing report(s). (3-19-07)

ii. All subsequent payments. (3-19-07)

b. Excessive reimbursement or non-covered services may precipitate immediate audit and settlement for the period(s) in question. Where such a determination is made, it may be necessary that the interim reimbursement rate (IRR) will be reduced. This reduction will be designated to effect at least one (1) of the following: (3-19-07)

i. Discontinuance of overpayments (on an interim basis). (3-19-07)

ii. Recovery of overpayments. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

225. NURSING FACILITY: COVERAGE AND LIMITATIONS.

An institution must provide, on a regular basis, health-related care and services to individuals; who because of their mental or physical condition require care and services above the level of room, board, and supervision. (3-19-07)

01. Nursing Facility Care. The minimum content of care and services for nursing facility patients must include the following: (3-19-07)

a. Room and board; (3-19-07)

b. Bed and bathroom linens; (3-19-07)

c. Nursing care, including special feeding if needed; (3-19-07)

d. Personal services; (3-19-07)

e. Supervision as required by the nature of the patient's illness and duration of his stay in the nursing facility; ~~(3-19-07)~~(7-1-10)T

f. Special diets as prescribed by a patient's physician; (3-19-07)

g. All common medicine chest supplies ~~which do not require a physician's prescription~~ that are over-the-counter including ~~but not limited to~~ mouthwashes, analgesics, laxatives, emollients, burn ointments, first aid cream, protective creams and liquids, cough and cold preparations, and simple eye preparations; ~~(3-19-07)~~(7-1-10)T

h. Dressings; (3-19-07)

i. Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; (3-19-07)

j. Application or administration of all drugs; (3-19-07)

k. All medical supplies including but not limited to gauzes, bandages, tapes, compresses, cottons, sponges, hot water bags, ice bags, disposable syringes, thermometers, cellucotton, incontinent supplies, or any other type of pads used to save labor or linen, and disposable gloves; ~~(3-19-07)~~(7-1-10)T

l. Social and recreational activities; and (3-19-07)

m. Each ~~I~~items ~~which are~~ that is utilized by individual patients ~~but which are~~ and is reusable and expected to be available, such as bed rails, canes, crutches, walkers, wheel chairs, traction equipment, and other durable medical equipment. ~~(3-19-07)~~(7-1-10)T

02. Skilled Services. Skilled services include services which could qualify as either skilled nursing or skilled rehabilitative services, which include: (3-19-07)

a. Overall management and evaluation of the care plan. The development, management, and evaluation of a resident's care plan, based on the physician's orders, constitute skilled services when, in terms of the patient's physical or mental condition, such development, management, and evaluation necessitate the involvement of technical or professional personnel to meet his needs, promote his recovery, and assure his medical safety. This would include the management of a plan involving only a variety of personal care services where, in light of the patient's condition, the aggregate of such services necessitates the involvement of technical or professional personnel. Where the patient's overall condition would support a finding that his recovery and safety could be assured only if the total care he requires is planned, managed, and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided. (3-19-07)

b. Observation and assessment of the resident's changing condition. When the resident's condition is such that the skills of a licensed nurse or other technical or professional person are required to identify and evaluate the patient's need for possible modification of treatment and the initiation of additional medical procedures until his condition is stabilized, such services constitute skilled services. (3-19-07)

03. Direct Skilled Nursing Services. Direct skilled nursing services include the following: (3-19-07)

a. Intravenous injections; intravenous feedings; intramuscular or subcutaneous injection required on more than one (1) shift; (3-19-07)

b. Nasopharyngeal feedings; (3-19-07)

c. Nasopharyngeal and tracheotomy aspiration; (3-19-07)

d. Insertion and sterile irrigation and replacement of catheters; (3-19-07)

e. Application of dressings involving prescription medications or aseptic techniques; (3-19-07)

f. Treatment of extensive decubitus ulcers or other widespread skin disorders; (3-19-07)

g. Heat treatments which have been specifically ordered by a physician as part of treatment and which require observation by nurses to adequately evaluate the resident's progress; and (3-19-07)

h. Initial phases of a regimen involving administration of oxygen. (3-19-07)

04. Direct Skilled Rehabilitative Services. Direct skilled rehabilitative services include the following: (3-19-07)

a. Ongoing assessment of rehabilitation needs and potential, services concurrent with the management of a resident's care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders; (3-19-07)

b. Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the resident, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the resident and the effectiveness of the treatment; (3-19-07)

c. Gait evaluation and training furnished by a physical or occupational therapist to restore function in a resident whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality; and (3-19-07)

d. Ultrasound, short-wave, and microwave therapy treatments by a licensed physical therapist. (3-19-07)

05. Other Treatment and Modalities. Other treatment and modalities which include hot pack, hydroculator, infrared treatments, paraffin baths, and whirlpool, in cases where the resident's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgement of a licensed physical therapist are required. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

257. NURSING FACILITY: DEVELOPMENT OF THE RATE.
Nursing facility rates are prospective, with new rates effective July 1st of each year, and are recalculated annually with quarterly adjustments for case mix. The rate for a nursing facility is the sum of the cost components described in Subsection 257.04 through 257.09 of this rule. In no case will the rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is made as computed by the lower of costs or customary charges. (5-8-09)

01. Applicable Case Mix Index (CMI). The Medicaid CMI used in establishing each facility's rate is

calculated based on the most recent assessment for each Medicaid resident in the nursing facility on the first day of the month of the preceding quarter (for example, assessments as of April 1are used to establish the CMI needed to establish rates for the quarter beginning July 1st). Facility-wide CMI is calculated based on the most recent assessment for all residents in the nursing facility. The CMI is recalculated quarterly and each nursing facility's rate is adjusted accordingly. A facility-wide CMI is also established each year by averaging four (4) calendar quarter CMIs for the cost reporting period from historical data to represent each fiscal quarter in the cost reporting period (for example, an October 1 CMI would represent the fiscal quarter ended September 30th). (3-19-07)

02. Applicable Cost Data. The cost data used in establishing the cost components of the rate calculation are from the audited or unaudited cost report which ended during the previous calendar year (for example, cost reports ending during the period from January 1, 1998 - December 31, 1998 are used in setting rates effective July 1, 1999). The draft audit of a cost report submitted by a facility will be issued by the Department no later than five (5) months after the date all information required for completion of the audit is filed with the Department. (3-19-07)

03. Interim Rates. Nursing facilities with unaudited cost reports are given an interim rate established by the Department until a rate is calculated based on an audited cost report. When audited data are available, a retroactive adjustment to the payment rate is made through the calculation of the finalized rate. (3-19-07)

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

a. The direct care per diem cost limit applicable to the rate period for a nursing facility type (free-standing and urban hospital-based nursing facility or rural hospital-based nursing facility) is identified. The identified direct care cost limit is divided by the statewide average CMI for the cost reporting period, and then multiplied by the nursing facility's facility-wide CMI for the cost reporting period to derive the adjusted direct care per diem cost limit. (3-19-07)

b. The adjusted direct care per diem cost limit is compared to the nursing facility's inflated direct care per diem costs. The lower of the two (2) amounts is then case mix adjusted. (3-19-07)

i. If the adjusted direct care per diem cost limit is lower, the adjusted limit is divided by the nursing facility's facility-wide CMI for the cost reporting period, and then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period to arrive at the direct care cost component. (3-19-07)

ii. If the inflated direct care per diem costs are lower, these costs, minus raw food and Medicaid related ancillary costs, are divided by the nursing facility's facility-wide CMI for the cost reporting period, then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period. Raw food and Medicaid related ancillary costs are then added back to arrive at the direct care cost component. (3-19-07)

05. Indirect Care Cost Component. The indirect care cost component of a facility's rate is the lesser of the facility's inflated indirect care per diem costs, or the indirect per diem cost limit for that type of provider -- free-standing and urban hospital-based nursing facilities, or rural hospital-based nursing facilities. (3-19-07)

~~***06. Efficiency Incentive**. The efficiency incentive is available to those providers, both free-standing and hospital-based, which have inflated per diem indirect care costs less than the indirect per diem cost limit for that type of provider. The efficiency incentive is calculated by multiplying the difference between the per diem indirect cost limit and the facility's inflated per diem indirect care costs by fifty percent (50%) not to exceed nine dollars and fifty cents ($9.50) per patient day. There is no incentive available to those facilities with per diem costs in excess of the indirect care cost limit, or to any facility based on the direct care cost component.* (3-29-10)~~

0~~7~~6. Costs Exempt From Limitation. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates as defined in Section 264 of these rules. (3-19-07)

0~~8~~7. Property Reimbursement. The property reimbursement component is calculated in accordance with Section 275 and Subsection 240.19 of these rules. (3-19-07)

0~~9~~8. Revenue Offset. Revenues from products or services provided to nonpatients will be offset from the corresponding rate component(s) as described in Section 257 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

270. NURSING FACILITY: SPECIAL RATES.
A special rate consists of a facility's daily reimbursement rate for a patient plus an add-on amount. Section 56-117, Idaho Code, provides authority for the Department to pay facilities an amount in addition to the daily rate when a patient has needs that are beyond the scope of facility services and when the cost of providing for those additional needs is not adequately reflected in the rates calculated pursuant to the principles found in Section 56-102, Idaho Code. This special rate add-on amount for such specialized care is in addition to any payments made in accordance with other provisions of this chapter and is excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, and these rules. (3-19-07)

01. Determination. The Department determines to approve a special rate on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request must be based on an identified condition that will continue for a period greater than ~~two~~ thirty (~~2~~30) ~~weeks~~ days. ~~(3-19-07)~~(7-1-10)T

02. Effective Date. Upon approval, a special rate is effective on the date the application was received~~, unless the provider requests a retroactive effective date. Special rates may be retroactive for up to thirty (30) days prior to receipt of the application~~. ~~(3-19-07)~~(7-1-10)T

03. Reporting. Costs equivalent to "grossed up" payments for special rate add-on amounts must be removed from the cost components subject to limits, and be reported separately by the provider. The grossed up amount is determined by dividing the Medicaid incremental revenue by Medicaid days and multiplying the result by total patient days. ~~(3-19-07)~~(7-1-10)T

04. Limitation. A special rate cannot exceed the provider's charges to other patients for similar services. (3-19-07)

05. Prospective Rate Treatment. Prospective treatment of special rates became effective July 1, 2000. Subsections 270.06 and 270.07 of these rules provide clarification of how special rates are paid under the prospective payment system. (3-19-07)

06. Determination of Payment for Qualifying Residents. Special rate add-on amounts are calculated using one (1) of the methods described in Subsections 270.06.a. through 270.06.e. of these rules. (3-19-07)

a. Special Care Units. If a facility operates a special care unit, such as a behavioral unit or a Traumatic Brain Injury (TBI) unit, reimbursement is determined as described in Subsections 270.06.a.i. through 270.06.a.v. of these rules. (3-19-07)

i. If the facility is below the direct care cost limit with special care unit costs included, no special rate is paid for the unit. (3-19-07)

ii. If the facility is over the direct care cost limit with special care unit costs included, a special rate add-on amount will be calculated. The special rate add-on amount for the unit is the lesser of the per diem amount by which direct care costs exceed the limit or a calculated add-on amount. The calculated special rate add-on is derived as follows: each Medicaid resident is assigned a total rate equal to the Medicare rate that would be paid if the resident were Medicare eligible. The resident's acuity adjusted Medicaid rate, based on each resident's individual Medicaid CMI, is subtracted from the Medicare rate. The average difference between the Medicaid and the Medicare rates for all special care unit residents is the calculated special rate add-on amount. The calculated special rate add-on amount is compared to the per diem amount by which the provider exceeds the direct care limit. The lesser of these two amounts is allowed as the special rate add-on amount for the unit. (3-19-07)

iii. New Unit Added After July 1, 2000. The Department must approve special rates for new special care units or increases to the number of licensed beds in an existing special care unit. Since a new unit will not have the cost history of an existing unit, the provider's relationship to the cap will not be considered in qualifying for a special rate. New units approved for special rates will have their special add-on amount calculated as the difference between the applicable Medicare price under PPS, and the acuity adjusted Medicaid rate for all unit residents as explained in Section 311.06.a.iii. of these rules. However, the average of these amounts is not limited to the amount the provider is over the direct care cost limit, as the costs of the unit are not in the rate calculation. (3-19-07)

iv. One Hundred Percent (100%) Special Care Facility Existing July 1, 2000. If on July 1, 2000, an entire facility was a special care unit which included Medicaid residents, the facility's direct care cost per diem will not be subject to the direct care cost limit. However, the direct care costs are case mix adjusted based on the ratio of the facility's Medicaid CMI for the rate period to the facility-wide CMI for the cost reporting period. (3-19-07)

v. Unit Routine Customary Charge. If the cost to operate a special care unit is being included in a facility's rate calculation process, the facility must report its usual and customary charge for a semi-private room in the unit on the quarterly reporting form, in addition to the semi-private daily room rate for the general nursing home population. A weighted average routine customary charge is computed to represent the composite of all Medicaid residents in the facility based on the type of rooms they occupy, including the unit. (3-19-07)

b. Equipment and Non-Therapy Supplies. Equipment and non-therapy supplies not addressed in Section 225 of these rules or adequately addressed in the current RUG system, as determined by the Department, are reimbursed ~~*at invoice cost*~~ in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 755, as an add-on amount. ~~*(3-19-07)*~~(7-1-10)T

c. Ventilator Dependent Residents and Residents Receiving Tracheostomy Care. The facility need not exceed the direct care limit to receive a special rate for ventilator care and tracheostomy care. In the case of ventilator dependent and tracheostomy residents, a two (2) step approach is taken to establish an add-on amount. The first step is the calculation of a staffing add-on for the cost, if any, of additional direct care staff required to meet the exceptional needs of these residents that is higher than the amount indicated on the resident's most recent Medicaid RUG score. The add-on is calculated following the provisions in Subsection 270.06.d. of ~~*these*~~ this rule~~s~~, adjusted for the appropriate skill level of care staff. The second step is the calculation of an add-on for equipment~~*, supplies, or both up to the invoice cost or rental amount*~~ and non-therapy supplies following the provision in Subsection 270.06.b. of this rule. The combined amount of these two (2) components is considered the special add-on amount to the facility's rate for approved residents receiving this care. ~~*(3-19-07)*~~(7-1-10)T

d. Residents Not Residing in a Special Care Unit Requiring One-to-One Staffing Ratios. Facilities may at times have residents who require unusual levels of staffing, such as one-to-one staffing ratios to meet the exceptional needs of that resident. If the staffing level is higher than the amount indicated on the resident's most recent Medicaid RUG score, the facility may request a special rate. If the resident qualifies for a special rate for additional direct care staff required to meet the exceptional needs of that resident, an hourly add-on rate is computed for reimbursement of approved one-to-one (1 to 1) hours in excess of the minimum staffing requirements in effect for the period. The hourly add-on rate is equal to the current WAHR CNA wage rate plus a benefits allowance ~~*of thirty percent (30%)*~~ based on annual cost report data, then weighted to remove the CNA Minimum daily staffing time.
~~*(3-19-07)*~~(7-1-10)T

~~***e.*** *Varying Levels of One-to-One Care. For varying levels of one-to-one care, such as eight (8) hours or twenty-four (24) hours, the total special rate add-on amount is calculated as the number of hours approved for one- to-one care times the hourly add-on rate as described in Subsection 270.06.d. The WAHR CNA wage rate as described in Section 307 of these rules will be updated prior to the July 1st rate setting each year. Should the WAHR survey be discontinued, the Department may index prior amounts forward, or conduct a comparable survey.*~~
~~*(3-19-07)*~~

07. Treatment of the Special Rate Cost for Future Rate Setting Periods. Special rates are established on a prospective basis similar to the overall facility rate. When the cost report used to set a prospective rate contains non-unit special rate cost, an adjustment is made to "offset," or reduce costs by an amount equal to total "grossed up" incremental revenues, or add-on payments received by the provider during the cost reporting period.

The amount received is calculated by multiplying the special rate add-on amount paid for each qualifying resident by the number of days that were paid. This calculated Medicaid amount will be grossed up by dividing the Medicaid incremental revenue by Medicaid days and multiplying the result by total patient days. No related adjustment is made to the facility's CMIs. ~~*(3-19-07)*~~(7-1-10)T

(BREAK IN CONTINUITY OF SECTIONS)

307. PERSONAL CARE SERVICES: PROVIDER REIMBURSEMENT.

01. Reimbursement Rate. Personal assistance providers will be paid a uniform reimbursement rate for service as established by the Department on an annual basis according to Section 39-5606, Idaho Code. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (3-19-07)

02. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical transportation, unless approved by the RMS under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as provided in Subsections 307.03 through 307.07 of these rules. (3-19-07)

03. Weighted Average Hourly Rates. Annually Medicaid will conduct a poll of all Idaho nursing facilities and ICFs/ID, and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, certified and non-certified nurse's aides) in Idaho to be used in calculating the reimbursement rate to be effective on July 1st of that year. (3-29-10)

04. Payment for Personal Assistance Agency. (7-1-10)T

a. The Department will establish Personal Assistance Agency rates for personal assistance services based on the WAHR~~*, plus the WAHR times a fifty five percent (55%) supplemental component to cover travel, administration, training, and all payroll taxes and fringe benefits, as follows:*~~ in accordance with Section 39-5606, Idaho Code. For State Fiscal Year 2011, this rate will only be adjusted if the prevailing hourly rate for comparable positions is less than the rate paid during State Fiscal Year 2010.

Personal Assistance Agencies	WAHR x ~~*1.55*~~ supplemental component	=	$ amount/hour

~~*(3-29-10)*~~(7-1-10)T

b. Beginning with State Fiscal Year 2011, every five (5) years the Department will conduct a survey of all Personal Assistance Agencies which requests the number of hours of all Direct Care Staff and the costs involved for all travel, administration, training, and all payroll taxes and fringe benefits. Based on the survey conducted, the Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. (7-1-10)T

c. Based on the survey conducted, provided that at least eighty-five percent (85%) of all Personal Assistance Agencies respond, the Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. If less than eighty-five percent (85%) of all Personal Assistance Agencies respond, the rate will remain at the WAHR rate without the supplemental component. (7-1-10)T

05. Payment Levels for Adults in Residential Care or Assisted Living Facilities or Certified Family Homes. Adult participants living in Residential Care or Assisted Living Facilities (RCALF) or Certified

Family Homes will receive personal care services at a rate based on their care level. Each level will convert to a specific number of hours of personal care services. (3-19-07)

a. Reimbursement Level I -- One point twenty-five (1.25) hours of personal care services per day or eight point seventy-five (8.75) hours per week. (3-19-07)

b. Reimbursement Level II -- One point five (1.5) hours of personal care services per day or ten point five (10.5) hours per week. (3-19-07)

c. Reimbursement Level III -- Two point twenty-five (2.25) hours of personal care services per day or fifteen point seventy-five (15.75) hours per week. (3-19-07)

d. Reimbursement Level IV - One point seventy-nine (1.79) hours of personal care services per day or twelve point five (12.5) hours per week. This level will be assigned based on a documented diagnosis of mental illness, intellectual disability, or Alzheimer's disease. If an individual is assessed as Level III with a diagnosis of mental illness, intellectual disability, or Alzheimer's disease the provider reimbursement rate will be the higher amount as described in Subsection 307.05.c. of these rules. (3-19-07)

06. Attending Physician Reimbursement Level. The attending physician or authorized provider will be reimbursed for services provided using current payment levels and methodologies for other services provided to eligible participants. (3-19-07)

07. Supervisory RN and QMRP Reimbursement Level. The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Participant evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the RMS. (3-19-07)

a. The number of supervisory visits by the RN or QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the RMS. (3-19-07)

b. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the RMS. (3-19-07)

08. Payment for PCS Family Alternate Care Home. The Department will establish PCS Family Alternate Care Home rates for personal assistance services based on the WAHR~~*, plus the product of the WAHR times fifty-five percent (55%) less the current payroll tax and fringe benefit rate to cover travel, administration, and training, as follows:*~~ in accordance with Section 39-5606, Idaho Code. Beginning with State Fiscal Year 2011, every five (5) years the Department will conduct a survey of all Personal Assistance Agency's which requests the number of hours of all Direct Care Staff and the indirect costs involved such as administration, and training. Based on the survey conducted, the Department will calculate a supplemental component using costs reported for administration, and training. The survey data is the cost information collected during the prior State Fiscal Year.

PCS Family Alternate Care Home	Children's PCS Assessment Weekly Hours x (WAHR x (~~*1.55 minus payroll taxes and fringe benefits cost percentage*~~ supplemental component)	=	$ amount/week

~~*(3-29-10)*~~(7-1-10)T

(BREAK IN CONTINUITY OF SECTIONS)

625. ~~*ICF/ID - EFFICIENCY INCREMENT*~~ (RESERVED).

~~*An efficiency increment will be included as a component of the prospective rate, or retrospective settlement if the allowable capped per diem costs are less than the cap.* (3-19-07)~~

~~***01. Computing Efficiency Increment.*** *The efficiency increment will be computed by subtracting the projected or, for facilities subject to retrospective settlement the actual allowable per diem costs incurred by the provider, from the applicable cap. This difference will be divided by five (5). The allowable increment is twenty cents ($.20) per one dollar ($1) below the cap up to a maximum increment of three dollars ($3) per participant day.*~~
~~*(7-1-97)*~~

~~***02. Determining Reimbursement.*** *Total reimbursement determined by adding amounts determined to be allowable, will not exceed the provider's usual and customary charges for these services as computed in accordance with this chapter and PRM. In computing participant days for the purpose of determining per diem costs, in those cases where the Medicaid Program or the participant is making payment for holding a bed in the facility, the participant will not be considered to be discharged and thus those days will be counted in the total.*~~ ~~*(3-19-07)*~~