LEGISLATURE OF THE STATE OF IDAHO

Sixty-first Legislature First Regular Session - 2011

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 260

BY WAYS AND MEANS COMMITTEE

AN ACT

RELATING TO MEDICAID; REPEALING SECTION 39-5606, IDAHO CODE, RELATING TO PAYMENT TO BE MADE TO A PROVIDER; REPEALING SECTION 56-102, IDAHO CODE, RELATING TO PRINCIPLES OF PROSPECTIVE RATES AND PAYMENT; AMENDING SECTION 56-108, IDAHO CODE, TO REVISE A CODE REFERENCE; REPEALING SECTION 56-113, IDAHO CODE, RELATING TO INTERMEDIATE CARE FACILITIES FOR PEOPLE WITH INTELLECTUAL DISABILITIES; AMENDING SECTION 56-117, IDAHO CODE, TO REVISE CODE REFERENCES; AMENDING SECTION 56-118, IDAHO CODE, TO REMOVE CERTAIN SERVICES FROM REIMBURSEMENT RATE REVIEW AND DETERMINATION, TO REMOVE AN ANNUAL REVIEW REQUIREMENT, TO PROVIDE FOR IMPLEMENTATION OF A CERTAIN METHODOLOGY BY RULE, TO REMOVE CERTAIN MINIMUM METHODOLOGY REQUIREMENTS, TO REMOVE CERTAIN REPORTING REQUIREMENTS AND TO REMOVE REFERENCE TO SUBSEQUENT RULES; REPEALING SECTION 56-136, IDAHO CODE, RELATING TO PHYSICIAN AND DENTIST REIMBURSEMENT; AMENDING SECTION 56-209g, IDAHO CODE, TO REMOVE AN OBSOLETE EFFECTIVE DATE, TO PROVIDE PAYMENT FOR DRUGS PURSUANT TO CERTAIN CRITERIA, TO PROVIDE FOR METHODOLOGY, TO ESTABLISH THE AVERAGE ACQUISITION COST OF A DRUG AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION 56-255, IDAHO CODE, TO PROVIDE FOR SERVICE REIMBURSEMENT WITHIN THE APPROPRIATIONS PROVIDED BY LAW, TO PROVIDE FOR MENTAL HEALTH SERVICES TO BE DELIVERED BY PROVIDERS THAT MEET CERTAIN STANDARDS, TO REVISE SPECIFIC HEALTH BENEFITS FOR PERSONS WITH DISABILITIES OR SPECIAL HEALTH NEEDS, TO REVISE BENEFITS FOR ALL MEDICAID PARTICIPANTS AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION 56-257, IDAHO CODE, TO PROVIDE FOR COPAYMENTS WITHIN THE LIMITS OF FEDERAL MEDICAID LAW AND REGULATION AND TO REVISE WHAT MAY BE INCLUDED IN COPAYMENTS ESTABLISHED BY THE DEPARTMENT OF HEALTH AND WELFARE; AMENDING CHAPTER 2, TITLE 56, IDAHO CODE, BY THE ADDITION OF NEW SECTIONS 56-260 THROUGH 56-266, IDAHO CODE, TO PROVIDE A SHORT TITLE, TO PROVIDE FOR LEGISLATIVE FINDINGS AND INTENT, TO PROVIDE FOR DEFINITIONS, TO PROVIDE FOR A MEDICAID MANAGED CARE PLAN, TO PROVIDE FOR RULEMAKING AUTHORITY REGARDING SPECIFIED SERVICES, TO PROVIDE FOR PROVIDER PAYMENT AND TO PROVIDE AUTHORIZATION TO OBTAIN FEDERAL APPROVAL; AMENDING SECTION 56-1408, IDAHO CODE, TO REVISE EXEMPTIONS TO THE HOSPITAL ASSESSMENT; AMENDING SECTION 56-1504, IDAHO CODE, TO REVISE A DATE ON WHICH CERTAIN RATES ARE EFFECTIVE, TO PROVIDE A RESTRICTION ON THE USE OF THE NURSING FACILITY ASSESSMENT FUND, TO PROVIDE FOR USE OF THE FUND FOR CERTAIN MATCHING PURPOSES AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION 56-1505, IDAHO CODE, TO REMOVE AN EXCEPTION, TO REVISE THE AGGREGATE AMOUNT OF ASSESSMENTS, THE FREQUENCY OF ASSESSMENTS AND WHEN ASSESSMENTS ARE DUE AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION 56-1511, IDAHO CODE, TO REMOVE AN EXCEPTION, TO REVISE THE FREQUENCY OF ASSESSMENTS, TO REVISE A DEFINITION, TO REVISE THE YEAR IN WHICH CERTAIN COST REPORTS SHALL BE APPLIED, TO PROVIDE WHAT INFORMATION IS TO BE USED UNDER CERTAIN CIRCUMSTANCES, TO REVISE THE TIME PERIOD IN WHICH AN ASSESSMENT PAYMENT IS

DUE AND TO PROVIDE FOR CONSEQUENCES IF AN ASSESSMENT IS NOT TIMELY PAID; REPEALING SECTIONS 56-1504, 56-1505 AND 56-1511, IDAHO CODE, RELATING TO THE NURSING FACILITY ASSESSMENT FUND, NURSING FACILITY ASSESSMENTS AND ANNUAL NURSING FACILITY ASSESSMENT PAYMENTS; AMENDING CHAPTER 15, TITLE 56, IDAHO CODE, BY THE ADDITION OF NEW SECTIONS 56-1504, 56-1505 AND 56-1511, IDAHO CODE, TO PROVIDE FOR THE NURSING FACILITY ASSESSMENT FUND, NURSING FACILITY ASSESSMENTS AND ANNUAL NURSING FACILITY ASSESSMENT PAYMENTS; AMENDING TITLE 56, IDAHO CODE, BY THE ADDITION OF A NEW CHAPTER 16, TITLE 56, IDAHO CODE, TO PROVIDE FOR A SHORT TITLE AND FOR LEGISLATIVE INTENT, TO DEFINE TERMS, TO PROVIDE FOR THE INTERMEDIATE CARE FACILITY ASSESSMENT FUND, TO PROVIDE FOR INTERMEDIATE CARE FACILITY ASSESSMENTS, TO REQUIRE THE DEPARTMENT OF HEALTH AND WELFARE TO SEEK NECESSARY FEDERAL APPROVAL, TO PROVIDE FOR SEPARATE INTERMEDIATE CARE FACILITY ASSESSMENTS FOR MULTIFACILITY LOCATIONS, TO PROVIDE FOR THE TERMINATION OF INTERMEDIATE CARE FACILITY ASSESSMENTS, TO PROVIDE FOR PENALTIES FOR FAILURE TO PAY THE INTERMEDIATE CARE FACILITY ASSESSMENT, TO PROVIDE FOR ANNUAL INTERMEDIATE CARE FACILITY ADJUSTMENT PAYMENTS AND TO PROVIDE FOR RULEMAKING AUTHORITY; PROVIDING SEVERABILITY; PROVIDING AN EFFECTIVE DATE AND PROVIDING A SUNSET DATE.

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

SECTION 1. That Section 39-5606, Idaho Code, be, and the same is hereby repealed.

SECTION 2. That Section 56-102, Idaho Code, be, and the same is hereby repealed.

SECTION 3. That Section 56-108, Idaho Code, be, and the same is hereby amended to read as follows:

56-108. PROPERTY REIMBURSEMENT -- FACILITIES WILL BE PAID A PROPERTY RENTAL RATE, PROPERTY TAXES AND REASONABLE PROPERTY INSURANCE. The provisions of this section shall not apply to hospital-based facilities which are subject to the provisions of section 56-120, Idaho Code, or to intermediate care facilities for people with intellectual disabilities which are subject to the provisions of section 56-~~113~~265, Idaho Code. The provisions of this section are applicable to all other facilities. The property rental rate includes compensation for major movable equipment but not for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. Prior to final audit, the director shall determine an interim rate that approximates the property rental rate. The property rental rate shall be determined as follows:

(1) Except as determined pursuant to this section:

Property rental rate = ("Property base") x ("Change in building costs") x $\frac{(40 - \text{"Age of facility"})}{40}$

where:

(a) "Property base" = $9.24 for all facilities.

(b) "Change in building costs" = 1.0 from April 1, 1985, through December 31, 1985. Thereafter "Change in building costs" will be adjusted for each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as of September of the prior year, published by the Marshall Swift Valuation Service. However, for freestanding skilled care facilities "change in building costs" = 1.145 from July 1, 1991, through December 31, 1991. Thereafter, change in building costs for freestanding skilled care facilities will be adjusted each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as of September of the prior year as published by the Marshall Swift Valuation Service or the consumer price index for renter's costs available in September of the prior year, whichever is greater.

(c) "Age of facility" = the director shall determine the effective age, in years, of the facility by subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof shall be assigned an age of more than thirty (30) years. However, beginning July 1, 1991, for freestanding skilled care facilities, "age of facility" will be a revised age which is the lesser of the age established under other provisions of this section or the age which most closely yields the rate allowable to existing facilities as of June 30, 1991, under subsection (1) of this section. This revised age shall not increase over time.

(i) If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the director shall set the effective age at thirty (30) years. Adequate documentation shall include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contracts, and original notes of indebtedness. The director shall compute an appropriate age for facilities when documentation is provided to reflect expenditures for building expansion or remodeling prior to the effective date of this section. The computation shall decrease the age of a facility by an amount consistent with the expenditure and the square footage impacted and shall be calculated as follows:

1. Determine, according to indexes published by the Marshall Swift Valuation Service, the construction cost per square foot of an average class D convalescent hospital in the western region for the year in which the expansion or renovation was completed.

2. Multiply the total square footage of the building following the expansion or renovation by the cost per square foot to establish the estimated replacement cost of the building at that time.

3. The age of the building at the time of construction shall be multiplied by the quotient of total actual renovation or remodeling costs divided by replacement cost. If this number is equal to or greater than 2.0, the age of the building

in years will be reduced by this number, rounded to the nearest whole number. In no case will the age be less than zero (0).

(ii) The director shall adjust the effective age of a facility when major repairs, replacement, remodeling or renovation initiated after April 1, 1985, would result in a change in age of at least one (1) year. Such changes shall not increase the allowable property rental rate by more than three-fourths (3/4) of the difference between the adjusted property base determined in subsections (1)(a) and (1)(b) of this section and the rental rate paid to the facility at the time of completion of such changes but before the change component has been added to said rate. The adjusted effective age of the facility will be used in future age determinations, unless modified by provisions of this chapter.

(iii) The director shall allow for future adjustments to the effective age of a facility or its rate to reimburse an appropriate amount for property expenditures resulting from new requirements imposed by state or federal agencies. The director shall, within twelve (12) months of verification of expenditure, reimburse the medicaid share of the entire cost of such new requirements as a one-time payment if the incurred cost for a facility is less than one hundred dollars ($100) per bed.

(d) At no time shall the property rental rate, established under subsection (1) of this section, be less than that allowed in subsection (1)(c)(ii), with the rate in effect December 31, 1988, being the base. However, subsequent to the application of this paragraph, before any rate increase may be paid, it must first be offset by any rate decrease that would have been realized if the provisions of this paragraph had not been in effect.

(2) A "grandfathered rate" for existing facilities will be determined by dividing the audited allowable annual property costs, exclusive of taxes and insurance, for assets on hand as of January 1, 1985, by the total patient days in the period July 1, 1984, through June 30, 1985. The property rental rate will be the greater of the amount determined pursuant to subsection (1) of this section, or the grandfathered rate. The director shall adjust the grandfathered rate of a facility to compensate the owner for the cost of major repairs, replacement, expansion, remodeling and renovation initiated prior to April 1, 1985, and completed after January 1, 1985, but completed no later than December 31, 1985. For facilities receiving a grandfathered rate making major repairs, replacement, expansion, remodeling or renovation, initiated after January 1, 1986, the director shall compare the grandfathered rate of the facility to the actual depreciation, amortization, and interest for the current audit period plus the per diem of the recognized cost of major repairs, replacement, expansion, remodeling or renovation, amortized over the American hospital association guideline component useful life. The greater of the two (2) numbers will be allowed as the grandfathered rate. Such changes shall not increase the allowable grandfathered rate by more than three-fourths (3/4) of the difference between the current grandfathered rate and the adjusted property base determined in subsections (1)(a) and (1)(b) of this section.

(3) The property rental rate per day of care paid to facilities with leases signed prior to March 30, 1981, will be the sum of the annualized allowed lease costs and the other annualized property costs for assets on hand as of January 1, 1985, exclusive of taxes and insurance when paid separately, divided by total patient days in the period June 30, 1983, through July 1, 1984. Effective July 1, 1989, the director shall adjust the property rental rate of a leased skilled facility under this paragraph to compensate for the cost of major repairs, replacement, expansion, remodeling and renovation initiated after January 1, 1985, by adding the per diem of the recognized cost of such expenditures amortized over the American hospital association guideline component useful life. Such addition shall not increase the allowable property rental rate by more than three-fourths (3/4) of the difference between the current property rental rate and the adjusted property base as determined in paragraphs (a) and (b) of subsection (1) of this section. Where such leases contain provisions that bind the lessee to accept an increased rate, reimbursement shall be at a rate per day of care which reflects the increase in the lease rate. Where such leases bind the lessee to the lease and allow the rate to be renegotiated, reimbursement shall be at a rate per day of care which reflects an annual increase in the lease rate not to exceed the increase in the consumer price index for renters costs. After the effective date of this subsection, if such a lease is terminated or if the lease allows the lessee the option to terminate other than by purchase of the facility, the property rental rate shall become the amount determined by the formula in subsection (1) of this section as of the date on which the lease is or could be terminated.

(4) (a) In the event of a sale, the buyer shall receive the property rental rate as provided in subsection (1) of this section, except under the conditions of paragraph (b) of this subsection or except in the event of the first sale for a freestanding skilled care facility receiving a grandfathered rate after June 30, 1991, whereupon the new owner shall receive the same rate that the seller would have received at any given point in time.

(b) In the event of a forced sale of a facility where the seller has been receiving a grandfathered rate, the buyer will receive a rate based upon his incurred property costs, exclusive of taxes and insurance, for the twelve (12) months following the sale, divided by the facility's total patient days for that period, or the property rental rate, whichever is higher, but not exceeding the rate that would be due the seller.

SECTION 4. That Section 56-113, Idaho Code, be, and the same is hereby repealed.

SECTION 5. That Section 56-117, Idaho Code, be, and the same is hereby amended to read as follows:

56-117. PAYMENT OF SPECIAL RATES. The director shall have authority to pay facilities at special rates for care given to patients who have long-term care needs not adequately reflected in the rates calculated pursuant to the principles set forth in section 56-~~102~~265, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter. The incremental cost to a facility that

exceeds the rate for services provided pursuant to the provisions of section 56-~~102~~265, Idaho Code, will be excluded from the computation of payments or rates under other provisions of this chapter. Until the facility applies for a special rate, patients with such needs will be included in the computation of the facility's rates following the principles described in section ~~56-102~~265, Idaho Code.

SECTION 6. That Section 56-118, Idaho Code, be, and the same is hereby amended to read as follows:

56-118. REIMBURSEMENT RATES. (1) The department shall implement a methodology for reviewing and determining reimbursement rates to private businesses providing developmental disability agency services, mental health services, service coordination and case management services~~,~~ and residential habilitation agency services ~~and affiliated residential habilitation specialized family home services annually~~ by rule.

(2) In addition to any policy or federal statutory requirements, such methodology shall incorporate, at a minimum, the ~~following:~~

~~(a)~~ ~~The~~ actual cost of providing quality services, including personnel and total operating expenses, directly related to providing such services which shall be provided by the private business entities~~;~~

~~(b) Changes in the expectations placed on private business providers in delivering services;~~

~~(c) Inflationary effects on the private business providers' ability to deliver the service since the last adjustment to the rate;~~

~~(d) Comparison of rates paid in neighboring states for comparable services;~~

~~(e) Comparison of any rates paid for comparable services in other public or private capacities~~.

(3) ~~A report of the results of this analysis and review shall be sent to the director, to the joint finance-appropriations committee and the health and welfare committees of the senate and the house of representatives by November 30 of each year. The department shall include in the report cost saving suggestions that private businesses shall provide. Any changes in reimbursement rates shall include estimated costs of implementation based on the current caseload forecasts and shall be submitted as part of the department's budget request required in section 67-3502, Idaho Code. Reimbursement rates included in appropriation bills enacted by the legislature shall become effective not later than July 1 of each year.~~

~~(4)~~ The results of this ~~annual~~ review and analysis ~~and subsequent rules~~ do not guarantee a change in reimbursement rates, but shall be a fair and equitable process for establishing and reviewing such rates.

SECTION 7. That Section 56-136, Idaho Code, be, and the same is hereby repealed.

SECTION 8. That Section 56-209g, Idaho Code, be, and the same is hereby amended to read as follows:

56-209g. PHARMACY REIMBURSEMENT. (1) Medicaid pharmacy reimbursement levels are a combination of the cost of the drug and a dispensing fee

which includes such pharmaceutical care services as counseling, obtaining a patient history, documentation~~,~~ and dispensing. ~~Effective July 1, 1998,~~ ~~p~~Pharmacy reimbursement levels may be adjusted in accordance with rules promulgated by the director through negotiated rulemaking with interested parties including representatives of the pharmacy profession.

(2) The department will pay the lesser of the provider's lowest charge to the general public for a drug or the estimated acquisition cost (EAC) plus a dispensing fee.

(a) The EAC is defined by the department as the average acquisition cost (AAC) of the drug, or when no AAC is available, reimbursement will be wholesale acquisition cost (WAC). WAC shall mean the price, paid by a wholesaler for the drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug as published by a recognized compendia of drug pricing on the last day of the calendar quarter that corresponds to the calendar quarter.

(b) The department shall establish pharmacy dispensing fee payments based on the results of surveys of pharmacies and dispensing rates paid to other payers. The dispensing fee structure will be tiered, with the tiers based on the annual medicaid claims volume of the enrolled Idaho retail pharmacy. All other pharmacy dispensing fees will be the lowest dispensing fee for the tiered structure.

(3) The AAC will be established by the department ~~will utilize periodic~~ by state ~~cost~~ or national surveys to ~~obtain the most accurate pharmacy drug acquisition costs in establishing a~~ the pharmacy ~~reimbursement fee schedule~~ for the product. When surveys are requested by the department to p~~P~~harmacies participating in the Idaho medicaid program, they are required to participate in these periodic state cost surveys by disclosing the costs of all drugs net of any special discounts or allowances. Participating pharmacies that refuse to respond to the periodic state surveys will be disenrolled as a medicaid provider.

SECTION 9. That Section 56-255, Idaho Code, be, and the same is hereby amended to read as follows:

56-255. MEDICAL ASSISTANCE PROGRAM -- SERVICES TO BE PROVIDED. (1) The department may make payments for the following services furnished by providers to participants who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be reimbursed only when medically necessary within the appropriations provided by law and in accordance with federal law and regulation, Idaho law and department rule. Notwithstanding any other provision of this chapter, medical assistance includes the following benefits specific to the eligibility categories established in section 56-254(1), (2) and (3), Idaho Code, as well as a list of benefits to which all Idaho medicaid participants are entitled, defined in subsection (5) of this section.

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

(a) All services described in subsection (5) of this section;

(b) Early and periodic screening, diagnosis and treatment services for individuals under age twenty-one (21) years, and treatment of conditions found; and

(c) Cost-sharing required of participants. Participants in the low-income children and working-age adult group are subject to the following premium payments, as stated in department rules:

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

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

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

(a) All services described in subsection (5) of this section;

(b) Early and periodic screening, diagnosis and treatment services for individuals under age twenty-one (21) years, and treatment of conditions found;

(c) Case management services as defined in accordance with section 1905(a)(19) or section 1915(g) of the social security act; and

(d) Mental health services delivered by providers that meet national accreditation standards, including:

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

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

(iii) Psychosocial rehabilitation for reduction of mental disability for children under the age of eighteen (18) years with a serious emotional disturbance (SED) ~~and for severely and persistently mentally ill adults,~~. Individuals aged~~ or older,~~ eighteen (18) years to age twenty-one (21) years with severe and persistent mental illness shall have access to benefits up to a weekly cap of five (5) hours while adults over the age of twenty-one (21) years with severe and persistent mental illness shall have access to benefits up to a weekly cap of four (4) hours;

(e) Long-term care services, including:

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

(ii) Home-based and community-based services, subject to federal approval, provided to individuals who require nursing facility level of care who, without home-based and community-based services, would require institutionalization. These services will include community supports, including ~~an~~ options for self-determination or family-directed, which will enable individuals to have greater freedom to manage their own care within the determined budget as defined by department rule; and

(iii) Personal care services in a participant's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse;

(f) Services for persons with developmental disabilities, including:

(i) Intermediate care facility services, other than such services in an institution for mental diseases, for persons determined in accordance with section 1902(a)(31) of the social security act to be in need of such care, including such services in a public institution, or distinct part thereof, for persons with intellectual disabilities or persons with related conditions;

(ii) Home-based and community-based services, subject to federal approval, provided to individuals who require an intermediate care facility for people with intellectual disabilities (ICF/ID) level of care who, without home-based and community-based services, would require institutionalization. These services will include community supports, including ~~an~~ options for self-determination or family-directed, which will enable individuals to have greater freedom to manage their own care within the determined budget as defined by department rule. The department shall respond to requests for budget modifications only when health and safety issues are identified and meet the criteria as defined in department rule; and

(iii) Developmental disability services~~. The department shall pay for rehabilitative services, including medical or remedial services provided by a facility that has entered into a provider agreement with the department and is certified as a developmental disabilities agency by the~~ for children and adults shall be available based on need through state plan services or waiver services as described in department rule. The department shall develop a blended rate covering both individual and group developmental therapy services; and

(g) Home health services, including:

(i) Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area;

(ii) Home health aide services provided by a home health agency; and

(iii) Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility;

(h) Hospice care in accordance with section 1905(o) of the social security act;

(i) Specialized medical equipment and supplies;

(j) Medicare cost-sharing, including:

(i) Medicare cost-sharing for qualified medicare beneficiaries described in section 1905(p) of the social security act;

(ii) Medicare part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the social security act;

(iii) Medicare part B premiums for specified low-income medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the social security act; and

(iv) Medicare part B premiums for qualifying individuals described in section 1902(a)(10)(E)(iv) and subject to section 1933 of the social security act; and

(k) Nonemergency medical transportation.

(4) Specific health benefits for persons over twenty-one (21) years of age who have medicare and medicaid coverage include:

(a) All services described in subsection (5) of this section, other than if provided under the federal medicare program;

(b) All services described in subsection (3) of this section, other than if provided under the federal medicare program;

(c) Other services that supplement medicare coverage; and

(d) Nonemergency medical transportation.

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

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

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

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

(iii) Hospital care, including:

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

2. Outpatient hospital services; and

3. Emergency hospital services;

(iv) Laboratory and x-ray services;

(v) Prescribed drugs;

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

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

(viii) Emergency medical transportation;

(ix) Mental health services, including:

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

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

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

(xi) Physical therapy and ~~related services~~ speech therapies combined to align with the annual medicare caps; and

(xii) Occupational therapy to align with the annual medicare cap;

(b) Primary care ~~case management~~ medical homes;

(c) Dental services~~, and medical and surgical services furnished by a dentist in accordance with section 1905(a)(5)(B) of the social security act~~. Children shall have access to prevention, diagnosis and treatment services as defined in federal law. Adult coverage shall be limited to medically necessary oral surgery and palliative services and associ-

ated diagnostic services. Select covered benefits include: exams, radiographs, periodontal, oral and maxillofacial surgery and adjunctive general services as defined in department rule. Pregnant women shall have access to dental services that reflect evidence-based practice;

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

(i) Podiatrists' services based on chronic care criteria as defined in department rule;

(ii) Optometrists' services based on chronic care criteria as defined in department rule;

(iii) Chiropractors' services shall be limited to six (6) visits per year; and

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

(e) Services for individuals with speech, hearing and language disorders~~, provided by or under the supervision of a speech pathologist or audiologist~~ as defined in department rule;

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

(g) Services provided by essential providers, including:

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

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

(iii) Indian health services;

(iv) District health departments; and

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

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

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

SECTION 10. That Section 56-257, Idaho Code, be, and the same is hereby amended to read as follows:

56-257. COPAYMENTS. (1) Within the limits of federal medicaid law and regulations, t~~T~~he department of health and welfare shall establish enforceable cost sharing in order to increase the awareness and responsibility of medicaid participants for the cost of their health care and to encourage use of cost-effective care in the most appropriate setting. Copayments established by department rule may include, but not be limited to, the following:

(a) ~~Inappropriate emergency room utilization. "Inappropriate emergency room utilization" means the use of the emergency room for services~~

~~that are nonemergency and that can be delivered in a regular clinic setting. If a hospital provider determines that it is reasonable that any prudent layperson would have sought emergency treatment in the same circumstances, a copayment will not be applied to such an individual even if the care rendered is nonemergency~~ Medicaid services including, but not limited to, chiropractic visits, podiatrist visits, optometrist visits, physical therapy visits, occupational therapy visits, speech therapy visits, outpatient hospital visits and physician office visits;

(b) Inappropriate use of emergency medicaid ~~funded medical transportation. "Inappropriate use of emergency medical transportation" means the use of~~ reimbursed services, including hospital emergency room and emergency ~~medical~~ transportation ~~for conditions that do not meet the criteria for emergency conditions specified in department rule~~; and

(c) ~~Missed appointments with health care providers. The department may limit the types of providers for which copayments for missed appointments are applicable. No such provider will be required by the department to collect copayments as required in this section; and~~

~~(d) Nonpreferred prescription drugs. A nonpreferred drug is a drug for which an alternative therapeutically interchangeable drug in the same pharmacological class is available whose use provides advantages to the medicaid program based on relative safety, effectiveness, clinical outcomes and cost. Pharmacy providers may be required to collect copayments at the point of service. Pharmacy providers shall not be required to dispense any prescribed medication unless a medicaid participant provides for any applicable copayment under this paragraph. Copayments shall not constitute a reduction of overall reimbursement to pharmacists for the dispensing of prescribed medicine~~ Missed appointments with health care providers when it is the practice of the health care provider to charge such copayments to all of their patients regardless of payer.

(2) The director may exempt, subject to federal approval, any group of medicaid participants from the cost-sharing provisions in this section.

SECTION 11. That Chapter 2, Title 56, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 56-260, Idaho Code, and to read as follows:

56-260. SHORT TITLE. Sections 56-260 through 56-266, Idaho Code, shall be known and may be cited as the "Medicaid Cost Containment and Health Care Improvement Act."

SECTION 12. That Chapter 2, Title 56, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 56-261, Idaho Code, and to read as follows:

56-261. LEGISLATIVE FINDINGS AND INTENT. (1) The legislature finds that the current health care delivery system of payment to medicaid health care providers on a fee for service basis does not provide the appropriate incentives and can be improved by incorporating managed care tools, in-

cluding capitation and selective contracting, with the objective of moving toward an accountable care system that results in improved health outcomes.

(2) The legislature intends that the provisions of sections 56-260 through 56-266, Idaho Code, result in the improved health of public assistance recipients while, at the same time, increasing the choices and responsibilities of those recipients. The legislature further intends that these sections result in improved business practices of providers.

(3) The legislature directs the department to pursue opportunities in the medicaid program that result in safe and appropriate discharge from public and private institutions including nursing homes, intermediate care facilities and psychiatric facilities into community settings and that such results should be financially sustainable.

(4) Price increases should be implemented only through specific appropriation authority unless the adjustments are specified in federal law.

SECTION 13. That Chapter 2, Title 56, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 56-262, Idaho Code, and to read as follows:

56-262. DEFINITIONS. The definitions contained in section 56-252, Idaho Code, shall apply to sections 56-260 through 56-266, Idaho Code.

SECTION 14. That Chapter 2, Title 56, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 56-263, Idaho Code, and to read as follows:

56-263. MEDICAID MANAGED CARE PLAN. (1) The department shall present to the legislature on the first day of the second session of the sixty-first Idaho legislature a plan for medicaid managed care with focus on high-cost populations including, but not limited to:

(a) Dual eligibles; and

(b) High-risk pregnancies.

(2) The medicaid managed care plan shall include, but not be limited to, the following elements:

(a) Improved coordination of care through primary care medical homes.

(b) Approaches that improve coordination and provide case management for high-risk, high-cost disabled adults and children that reduce costs and improve health outcomes, including mandatory enrollment in special needs plans, and that consider other managed care approaches.

(c) Managed care contracts to pay for behavioral health benefits as described in executive order number 2011-01 and in any implementing legislation. At a minimum, the system should include independent, standardized, statewide assessment and evidence-based benefits provided by businesses that meet national accreditation standards.

(d) The elimination of duplicative practices that result in unnecessary utilization and costs.

(e) Contracts based on gain sharing, risk-sharing or a capitated basis.

(f) Medical home development with focus on populations with chronic disease using a tiered case management fee.

SECTION 15. That Chapter 2, Title 56, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 56-264, Idaho Code, and to read as follows:

56-264. RULEMAKING AUTHORITY. In addition to the rulemaking authority granted to the department in this chapter and elsewhere in Idaho Code regarding the medicaid program and notwithstanding any other Idaho law to the contrary, the department shall have the authority to promulgate rules regarding:

(1) Medical services to:

(a) Change the primary case management paid to providers to a tiered payment based on the health needs of the populations that are managed. A lower payment is to be made for healthier populations and a higher payment is to be made for individuals with special needs, disabilities or are otherwise at risk. An incentive payment is to be provided to practices that provide extended hours beyond the normal business hours that help reduce unnecessary higher-cost emergency care;

(b) Provide that a healthy connections referral is no longer required for urgent care as an alternative to higher cost but unnecessary emergency services; and

(c) Eliminate payment for collateral contact;

(2) Mental health services to:

(a) Eliminate administrative requirements for a functional and intake assessment and add a comprehensive diagnostic assessment addendum;

(b) Restrict duplicative skill training from being provided by a mental health provider when the individual has chosen to receive skill training from a developmental disability provider. The individual may choose to receive skill training from a mental health provider but can not receive skill building simultaneously from two (2) providers;

(c) Increase the criteria for accessing the partial care benefit and restrict to those individuals who have a diagnosis of serious and persistent mental illness;

(d) Eliminate the requirement for new annual plans; and

(e) Direct the department to develop an effective management tool for psychosocial rehabilitation services;

(3) In-home care services to:

(a) Eliminate personal care service coordination; and

(b) Restrict duplicative nursing services from a home health agency when nursing services are being provided through the aged and disabled waiver;

(4) Vision services to:

(a) Align coverage requirements for contact lenses with commercial insurers and other state medicaid programs; and

(b) Limit coverage for adults based on chronic care criteria;

(5) Audiology services to eliminate audiology benefits for adults;

(6) Developmental disability services to:

(a) Eliminate payment for collateral contact;

(b) Eliminate supportive counseling benefit;

(c) Reduce annual assessment hours from twelve (12) to four (4) hours and exclude psychological and neuropsychological testing services within these limits;
(d) Reduce plan development payment from twelve (12) to six (6) hours and reduce requirements related to adult developmental disabilities plan development;
(e) Restrict duplicative skill training from being provided by a developmental disabilities provider when an individual has chosen to receive skill training from his mental health provider;
(f) Implement changes to certified family homes pursuant to chapter 31, title 39, Idaho Code, to:
(i) Create approval criteria and process for approving new certified family homes;
(ii) Recertify current certified family homes; and
(iii) Develop applicant and licensing fees to cover certifying and recertifying costs;
(g) Move individualized adult budgets to a tiered approach as currently used by the department for children's developmental therapy; and
(7) Institutional care services to discharge individuals from institutional settings where such services are no longer necessary.

SECTION 16. That Chapter 2, Title 56, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 56-265, Idaho Code, and to read as follows:

56-265. PROVIDER PAYMENT. (1) Where there is an equivalent, the payment to medicaid providers:
(a) May be up to but shall not exceed one hundred percent (100%) of the current medicare rate for primary care procedure codes as defined by the centers for medicare and medicaid services; and
(b) Shall be ninety percent (90%) of the current medicare rate for all other procedure codes.
(2) Where there is no medicare equivalent, the payment rate to medicaid providers shall be prescribed by rule.
(3) The department shall, through the annual budget process, include a line item request for adjustments to provider rates. All changes to provider payment rates shall be subject to approval of the legislature by appropriation.

SECTION 17. That Chapter 2, Title 56, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 56-266, Idaho Code, and to read as follows:

56-266. AUTHORIZATION TO OBTAIN FEDERAL APPROVAL. The department is authorized to obtain federal approval for the requirements set forth in sections 56-260 through 56-266, Idaho Code.

SECTION 18. That Section 56-1408, Idaho Code, be, and the same is hereby amended to read as follows:

56-1408. EXEMPTIONS. (1) ~~A~~ State hospital ~~that is a governmental entity, including a state agency, is~~ south in Blackfoot, Idaho, and state hospital north in Orofino, Idaho, and the department of veterans affairs medical center in Boise, Idaho, are exempt from the assessment required by section 56-1404, Idaho Code~~, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital shall pay such assessment~~.

(2) A private hospital that does not provide emergency services through an emergency department and is not categorized as "rehabilitation" or "psychiatric" as provided in section II.C. of the "application for hospital licenses and annual report -- 2007" by the bureau of facility standards of the department of health and welfare, is exempt from the assessment required by section 56-1404, Idaho Code.

SECTION 19. That Section 56-1504, Idaho Code, be, and the same is hereby amended to read as follows:

56-1504. NURSING FACILITY ASSESSMENT FUND. (1) There is hereby created in the office of the state treasurer a dedicated fund to be known as the nursing facility assessment fund, hereinafter the "fund," to be administered by the department. The state treasurer shall invest idle moneys in the fund and any interest received on those investments shall be returned to the fund.

(2) Moneys in the fund shall consist of:

(a) All moneys collected or received by the department from nursing facility assessments required by this chapter;

(b) All federal matching funds received by the department as a result of expenditures made by the department that are attributable to moneys deposited in the fund;

(c) Any interest or penalties levied in conjunction with the administration of this chapter; and

(d) Any appropriations, federal funds, donations, gifts or moneys from any other sources.

(3) The fund is created for the purpose of receiving moneys in accordance with this section and section 56-1511, Idaho Code. Collected assessment funds shall be used to secure federal matching funds available through the state medicaid plan, which funds shall be used to make medicaid payments for nursing facility services ~~which~~ that equal or exceed the amount of nursing facility medicaid rates, in the aggregate, as calculated in accordance with the approved state medicaid plan in effect on ~~June 30~~ November 15, 201~~0~~9. The fund shall not be used to replace any moneys appropriated to the Idaho medical assistance program by the legislature. Moneys in t~~T~~he fund shall be used exclusively for the following purposes:

(a) To pay administrative expenses incurred by the department or its agent in performing the activities authorized by this chapter, provided that such expenses shall not exceed a total of one percent (1%) of the aggregate assessment funds collected for the prior fiscal year.

(b) To reimburse the medicaid share of the assessment as a pass-through.

(c) To, at a minimum, make nursing facility adjustment payments that restore any rate reductions, in the aggregate, for the state fiscal years 2010 and 2011.

(d) To increase nursing facility payments to fund covered services to medicaid beneficiaries within medicare upper payment limits, as negotiated with the department.

(e) To repay the federal government any excess payments made to nursing facilities if the state plan, once approved by CMS, is subsequently disapproved for any reason, and after the state has appealed the findings. Nursing facilities shall refund the excess payments in question to the assessment fund. The state, in turn, shall return funds to both the federal government and nursing facility providers in the same proportion as the original financing. Individual nursing facilities shall be reimbursed based on the proportion of the individual nursing facility's assessment to the total assessment paid by nursing facilities. If a nursing facility is unable to refund payments, the state shall develop a payment plan and deduct moneys from future medicaid payments. The state will refund the federal government for the federal share of these overpayments.

(f) To make refunds to nursing facilities pursuant to section 56-1507, Idaho Code.

(g) To provide state matching funds for the department medicaid trustee and benefit expenditures to the extent that a general fund shortfall exists, or as limited by the maximum assessment as set forth in section 56-1505(2), Idaho Code, whichever is less.

SECTION 20. That Section 56-1505, Idaho Code, be, and the same is hereby amended to read as follows:

56-1505. NURSING FACILITY ASSESSMENTS. (1) Nursing facilities shall pay the nursing facility assessment to the fund in accordance with the provisions of this chapter, with the exception of state ~~and county-owned~~ facilities, which are not required to contribute.

(2) The aggregated amount of assessments for all nursing facilities, during a fiscal year, shall be an amount not exceeding ~~two percent (2%)~~ the maximum percentage allowed under federal law of the total aggregate net patient service revenue of assessed facilities from each provider's prior fiscal year. The department shall determine the assessment rate prospectively for the applicable fiscal year on a per-resident-day basis, exclusive of medicare part A resident days. The per-resident-day assessment rate shall be uniform. The department shall notify nursing facilities of the assessment rate applicable to the fiscal year by August 30 of that fiscal year.

(3) The department shall collect, and each nursing facility shall pay, the nursing facility assessment on ~~a quarterly~~ an annual basis subject to the terms of this subsection. The nursing facility assessment shall be ~~due quarterly with the initial payment due within sixty (60) days after the state plan has been approved by CMS. Subsequent quarterly payments are~~ due no later than thirty (30) days after ~~the end of the calendar quarter~~ receipt of the department invoice.

(4) Nursing facilities may increase their charges to other payers to incorporate the assessment but shall not create a separate line item charge on the bill reflecting the assessment.

SECTION 21. That Section 56-1511, Idaho Code, be, and the same is hereby amended to read as follows:

56-1511. ~~QUARTERLY~~ ANNUAL NURSING FACILITY ADJUSTMENT PAYMENTS. (1) All nursing facilities, with the exception of the state ~~and county-owned~~ facilities, shall be eligible for ~~quarterly~~ annual nursing facility adjustments.

(2) For the purpose of this section, "~~nursing facility~~medicaid days" are days of nursing facility services paid for by the Idaho medical assistance program for the applicable state fiscal year.

(a) For state fiscal year 201~~0~~1, medicaid days for each provider's cost report ending in calendar year 2008, shall be utilized to determine the nursing facility adjustment payment. When there is not a change in ownership, adjustment payments for a new provider without a full year 2008 cost report shall be determined using more current medicaid patient day information obtained from the provider.

(b) For state fiscal year 201~~1~~2, medicaid days for each provider's cost report ending in calendar year 2009, shall be utilized to determine the nursing facility adjustment payment. When there is not a change in ownership, adjustment payments for a new provider without a full year 2009 cost report shall be determined using more current medicaid patient day information obtained from the provider.

(3) Adjustment payments shall be paid on ~~a quarterly~~ an annual basis to reimburse covered medicaid expenditures in the aggregate within the upper payment limit.

(4) ~~Each quarterly payment shall be made no later than~~ If a provider does not pay its annual assessment within thirty (30) days after the receipt of the ~~last quarterly deposit of the nursing facility assessments required in section 56-1504, Idaho Code~~ department invoice, no further rate adjustment payments shall be made to the provider until the receipt of all assessments in arrears. If a provider pays its annual assessment more than sixty (60) days after receiving the department invoice, the subsequent adjustment payment shall be reduced twenty percent (20%).

(5) The provisions of this section shall be null, void and of no force and effect on July 1, 201~~1~~2.

SECTION 22. That Sections 56-1504, 56-1505 and 56-1511, Idaho Code, be, and the same are hereby repealed.

SECTION 23. That Chapter 15, Title 56, Idaho Code, be, and the same is hereby amended by the addition thereto of NEW SECTIONS, to be known and designated as Sections 56-1504, 56-1505 and 56-1511, Idaho Code, and to read as follows:

56-1504. NURSING FACILITY ASSESSMENT FUND. (1) There is hereby created in the office of the state treasurer a dedicated fund to be known as the nursing facility assessment fund, hereinafter the "fund," to be adminis-

tered by the department. The state treasurer shall invest idle moneys in the fund and any interest received on those investments shall be returned to the fund.

(2) Moneys in the fund shall consist of:

(a) All moneys collected or received by the department from nursing facility assessments required pursuant to this chapter;

(b) All federal matching funds received by the department as a result of expenditures made by the department that are attributable to moneys deposited in the fund;

(c) Any interest or penalties levied in conjunction with the administration of this chapter; and

(d) Any appropriations, federal funds, donations, gifts or moneys from any other sources.

(3) The fund is created for the purpose of receiving moneys in accordance with this section and section 56-1511, Idaho Code. Collected assessment funds shall be used to secure federal matching funds available through the state medicaid plan, which funds shall be used to make medicaid payments for nursing facility services that equal or exceed the amount of nursing facility medicaid rates, in the aggregate, as calculated in accordance with the approved state medicaid plan in effect on June 30, 2009. The fund shall be used exclusively for the following purposes:

(a) To pay administrative expenses incurred by the department or its agent in performing the activities authorized pursuant to this chapter, provided that such expenses shall not exceed a total of one percent (1%) of the aggregate assessment funds collected for the prior fiscal year.

(b) To reimburse the medicaid share of the assessment as a pass-through.

(c) To, at a minimum, make nursing facility adjustment payments that restore any rate reductions, in the aggregate, for the state fiscal years 2010 and 2011.

(d) To increase nursing facility payments to fund covered services to medicaid beneficiaries within medicare upper payment limits, as negotiated with the department.

(e) To repay the federal government any excess payments made to nursing facilities if the state plan, once approved by CMS, is subsequently disapproved for any reason, and after the state has appealed the findings. Nursing facilities shall refund the excess payments in question to the assessment fund. The state, in turn, shall return funds to both the federal government and nursing facility providers in the same proportion as the original financing. Individual nursing facilities shall be reimbursed based on the proportion of the individual nursing facility's assessment to the total assessment paid by nursing facilities. If a nursing facility is unable to refund payments, the state shall develop a payment plan and deduct moneys from future medicaid payments. The state will refund the federal government for the federal share of these overpayments.

(f) To make refunds to nursing facilities pursuant to section 56-1507, Idaho Code.

56-1505. NURSING FACILITY ASSESSMENTS. (1) Nursing facilities shall pay the nursing facility assessment to the fund in accordance with the provisions of this chapter, with the exception of state and county-owned facilities, which are not required to contribute.

(2) The aggregated amount of assessments for all nursing facilities, during a fiscal year, shall be an amount not exceeding the maximum percentage allowed under federal law of the total aggregate net patient service revenue of assessed facilities from each provider's prior fiscal year. The department shall determine the assessment rate prospectively for the applicable fiscal year on a per-resident-day basis, exclusive of medicare part A resident days. The per-resident-day assessment rate shall be uniform. The department shall notify nursing facilities of the assessment rate applicable to the fiscal year by August 30 of that fiscal year.

(3) The department shall collect, and each nursing facility shall pay, the nursing facility assessment on an annual basis subject to the terms of this subsection. The nursing facility assessment shall be due annually with the initial payment due within sixty (60) days after the state plan has been approved by CMS. Subsequent annual payments are due no later than thirty (30) days after receipt of the department invoice.

(4) Nursing facilities may increase their charges to other payers to incorporate the assessment but shall not create a separate line item charge on the bill reflecting the assessment.

56-1511. ANNUAL NURSING FACILITY ADJUSTMENT PAYMENTS. (1) All nursing facilities, with the exception of the state and county-owned facilities, shall be eligible for annual nursing facility adjustments.

(2) For the purpose of this section, "nursing facility days" are days of nursing facility services paid for by the Idaho medical assistance program for the applicable state fiscal year.

(a) For state fiscal year 2010, medicaid days for each provider's cost report ending in calendar year 2008 shall be utilized to determine the nursing facility adjustment payment.

(b) For state fiscal year 2011, medicaid days for each provider's cost report ending in calendar year 2009 shall be utilized to determine the nursing facility adjustment payment.

(3) Adjustment payments shall be paid on an annual basis to reimburse covered medicaid expenditures in the aggregate within the upper payment limit.

(4) Each annual payment shall be made no later than thirty (30) days after the receipt of the last annual deposit of the nursing facility assessments required in section 56-1504, Idaho Code.

SECTION 24. That Title 56, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW CHAPTER, to be known and designated as Chapter 16, Title 56, Idaho Code, and to read as follows:

CHAPTER 16
IDAHO INTERMEDIATE CARE FACILITY ASSESSMENT ACT

56-1601. SHORT TITLE -- LEGISLATIVE INTENT. (1) This chapter shall be known and may be cited as the "Idaho Intermediate Care Facility Assessment Act."

(2) It is the intent of the legislature to encourage the maximization of financial resources eligible and available for medicaid services by establishing a fund within the Idaho department of health and welfare to receive ICF assessments to be used in securing federal matching funds under federally prescribed programs available through the state medicaid plan.

56-1602. DEFINITIONS. As used in this chapter:

(1) "CMS" means the centers for medicare and medicaid services.

(2) "Department" means the Idaho department of health and welfare.

(3) "Fiscal year" means the time period from July 1 to June 30.

(4) "Fund" means the ICF assessment fund established pursuant to section 56-1603, Idaho Code.

(5) "ICF" means an intermediate care facility for people with intellectual disabilities as defined in section 39-1301, Idaho Code, and licensed pursuant to chapter 13, title 39, Idaho Code.

(6) "Net patient service revenue" means gross revenues from services provided to ICF patients, less reductions from gross revenue resulting from an inability to collect payment of charges. Patient service revenue excludes nonpatient care revenues such as beauty and barber, vending income, interest and contributions, revenues from sale of meals and all outpatient revenues. Reductions from gross revenue includes: bad debts; contractual adjustments; uncompensated care; administrative, courtesy and policy discounts and adjustments; and other such revenue deductions.

(7) "Resident day" means a calendar day of care provided to an ICF resident, including the day of admission and excluding the day of discharge, provided that one (1) resident day shall be deemed to exist when admission and discharge occur on the same day.

(8) "Upper payment limit" means the limitation established in 42 CFR section 447.272, that disallows federal matching funds when state medicaid agencies pay certain classes of facilities an aggregate amount for services that exceed the amount that is paid for the same services furnished by that class of facilities under medicare payment principles.

56-1603. INTERMEDIATE CARE FACILITY ASSESSMENT FUND. (1) There is hereby created in the office of the state treasurer a dedicated fund to be known as the ICF assessment fund to be administered by the department. The state treasurer shall invest idle moneys in the fund, and any interest received on those investments shall be returned to the fund.

(2) Moneys in the fund shall consist of:

(a) All moneys collected or received by the department from ICF assessments required pursuant to this chapter;

(b) All federal matching funds received by the department as a result of expenditures made by the department that are attributable to moneys deposited in the fund;

(c) Any interest or penalties levied in conjunction with the administration of this chapter; and

(d) Any appropriation or federal funds.

(3) The fund is created for the purpose of receiving moneys in accordance with the provisions of this section and section 56-1604, Idaho Code. The fund shall not be used to replace any moneys appropriated to the Idaho medical assistance program by the legislature. Moneys in the fund, which are deemed to be perpetually appropriated, shall be used exclusively for the following purposes:

(a) To pay administrative expenses incurred by the department or its agent in performing the activities authorized pursuant to this chapter, provided that such expenses shall not exceed a total of one percent (1%) of the aggregate assessment funds collected for the prior fiscal year.

(b) To reimburse the medicaid share of the assessment as a pass-through.

(c) To secure federal matching funds available through the state medicaid plan, which funds shall be used to make medicaid payments for ICF services that equal or exceed the amount of ICF medicaid rates, in the aggregate, as calculated in accordance with the approved state medicaid plan in effect on July 1, 2011.

(d) To increase ICF payments to fund covered services to medicaid beneficiaries within medicare upper payment limits.

(e) To, at a minimum, make ICF adjustment payments that restore any rate reductions, in the aggregate, for the state fiscal years 2011 and 2012, within medicare upper payment limits.

(f) To make refunds to ICFs pursuant to section 56-1607, Idaho Code. If an ICF is unable to refund payments, the state shall develop a payment plan and deduct moneys from future medicaid payments. The state will refund the federal government for the federal share of these overpayments.

(g) To make transfers to any other fund in the state treasury, provided such transfers shall not exceed the amount transferred previously from that other fund into the ICF assessment fund.

(h) To provide state matching funds for department medicaid trustee and benefit expenditures to the extent that a general fund shortfall exists, or as limited by the maximum assessment as set forth in section 56-1604(2), Idaho Code, whichever is less.

56-1604. INTERMEDIATE CARE FACILITY ASSESSMENTS. (1) The ICF shall pay the ICF assessment to the fund in accordance with the provisions of this chapter.

(2) The aggregated amount of assessments for all ICFs during a fiscal year shall be an amount not exceeding the maximum percentage allowed under federal law of the total aggregate net patient service revenue of assessed ICFs from each provider's prior fiscal year. The department shall determine the assessment rate prospectively for the applicable fiscal year on a per-resident-day basis. The per-resident-day assessment rate shall be uniform for all ICFs.

(3) The department shall collect, and each ICF shall pay, the ICF assessment on an annual basis subject to the terms of this subsection. The ICF assessment shall be due no later than thirty (30) days after the receipt of the department invoice.

56-1605. APPROVAL OF STATE PLAN. The department shall seek necessary federal approval in the form of the state plan amendments in order to implement the provisions of this chapter.

56-1606. MULTIFACILITY LOCATIONS. If an entity conducts, operates or maintains more than one (1) ICF licensed by the department, the entity shall pay the assessment for each ICF separately.

56-1607. TERMINATION OF ICF ASSESSMENTS. (1) The ICF assessment shall terminate and the department shall discontinue the imposition, assessment and collection of the ICF assessment if the plan amendment incorporating the payment in section 56-1604, Idaho Code, is not approved by CMS. In the event that CMS subsequently determines that the operation of this assessment program fails to abide by federal statute, regulation and/or CMS policy, the state shall return funds back to the providers on a pro rata basis of the assessments collected. The payment calculations in sections 56-1604 and 56-1609, Idaho Code, may be modified if necessary to obtain CMS approval of the plan amendment.

(2) Upon termination of the assessment, all collected assessment revenues, less any amounts expended by the department, shall be returned on a pro rata basis to ICFs that paid the ICF assessment.

56-1608. PENALTIES FOR FAILURE TO PAY INTERMEDIATE CARE FACILITY ASSESSMENT. (1) If an ICF fails to pay the full amount of an ICF assessment when due, there shall be added to the assessment, unless waived by the department for reasonable cause, a penalty equal to five percent (5%) of the amount of the assessment that was not paid when due. Any subsequent payments shall be credited first to unpaid assessment amounts rather than to penalty or interest amounts, beginning with the most delinquent installment.

(2) In addition to the penalty identified in subsection (1) of this section, the department may seek any of the following remedies for failure of any ICF to pay its assessment when due:

(a) Withhold any medical assistance reimbursement payments until such time as the assessment amount is paid in full;

(b) Suspend or revoke the ICF license; or

(c) Develop a plan that requires the ICF to pay any delinquent assessment in installments.

56-1609. ANNUAL INTERMEDIATE CARE FACILITY ADJUSTMENT PAYMENTS. (1) All ICFs shall be eligible for annual ICF adjustments.

(2) For the purpose of this section, "medicaid days" are days of ICF services paid for by the Idaho medical assistance program for the applicable state fiscal year.

(a) For state fiscal year 2011, medicaid days for each provider's cost report ending in calendar year 2009 shall be utilized to determine the ICF adjustment payment.

(b) For state fiscal year 2012, medicaid days for each provider's cost report ending in calendar year 2010 shall be utilized to determine the ICF adjustment payment.

(c) Adjustment payments for a new provider, not new ownership, without a full year cost report shall be determined using medicaid patient day information from the full calendar quarter of business prior to the rate adjustment quarter.

(3) Adjustment payments shall be paid on an annual basis to reimburse covered medicaid expenditures in the aggregate within the upper payment limit.

(4) If a provider does not pay its annual assessment within thirty (30) days after receipt of the department invoice, no further rate adjustment payments shall be made to the provider until receipt of all assessments in arrears. If a provider pays its annual assessment more than sixty (60) days after receiving the department invoice, the subsequent adjustment payment shall be reduced twenty percent (20%).

56-1610. RULEMAKING AUTHORITY. The department shall adopt rules to implement the provisions of this chapter.

SECTION 25. SEVERABILITY. The provisions of this act are hereby declared to be severable and if any provision of this act or the application of such provision to any person or circumstance is declared invalid for any reason, such declaration shall not affect the validity of the remaining portions of this act.

SECTION 26. Sections 22 and 23 of this act shall be in full force and effect on and after July 1, 2012. The provisions of Section 24 of this act shall be null, void and of no force and effect on and after July 1, 2012.