Dear Senators LODGE, Broadsword, Bock, and
Representatives MCGEACHIN, Bilbao, Rusche:

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

IDAPA 16.03.09 - Rules Pertaining To Medicaid Basic Plan Benefits (Health Home) (Docket No. 16-0309-1205);

IDAPA 16.03.09 - Rules Pertaining To Medicaid Basic Plan Benefits (EPSDT coverage) (Docket No. 16-0309-1206);

IDAPA 16.03.10 - Rules Pertaining To Medicaid Enhanced Plan Benefits (Provider Rates of Reimbursement) (Docket No. 16-0310-1201);

IDAPA 16.03.10 - Rules Pertaining To Medicaid Enhanced Plan Benefits (New Behavioral Care Units (BCU) in Nursing Facilities) (Docket No. 16-1310-1205).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research and Legislation no later than fourteen (14) days after receipt of the rules analysis from Legislative Services. The final date to call a meeting on the enclosed rules is no later than 10/16/2012. 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 11/14/2012.

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 on the memorandum attached below.

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: Legislative Research Analyst - Ryan Bush

DATE: September 26, 2012

SUBJECT: Department of Health and Welfare - Medicaid Basic Plan Benefits, Medicaid Enhanced Plan Benefits

IDAPA 16.03.09 - Rules Pertaining To Medicaid Basic Plan Benefits (Health Home) (Docket No. 16-0309-1205)

IDAPA 16.03.09 - Rules Pertaining To Medicaid Basic Plan Benefits (EPSDT coverage) (Docket No. 16-0309-1206)

IDAPA 16.03.10 - Rules Pertaining To Medicaid Enhanced Plan Benefits (Provider Rates of Reimbursement) (Docket No. 16-0310-1201)

IDAPA 16.03.10 - Rules Pertaining To Medicaid Enhanced Plan Benefits (New Behavioral Care Units (BCU) in Nursing Facilities) (Docket No. 16-1310-1205)

(1) 16.03.09 - Rules Pertaining To Medicaid Basic Plan Benefits (Health Home) (Docket No. 16-0309-1205)

The Department of Health and Welfare submits notice of proposed rulemaking at IDAPA 16.03.09 - Rules Pertaining To Medicaid Basic Plan Benefits (Health Home). The Department states that the proposed rulemaking is to address the Governor's medical home initiative by providing for the administration of the Idaho Medicaid Health Home program. The Department further states that this rulemaking updates and revises the rules for the Healthy Connections program to describe the relationship between the Health Home program and Healthy Connections. Specifically, this rulemaking accomplishes the following:

(1) Revises procedural requirements for outpatient hospital services to account for the Health Home program;

(2) Defines and revises terms related to the Health Home program;

(3) Revises participant eligibility; coverage and limitations; procedural requirements; and provider qualifications, duties, and reimbursement for Healthy Connections;

(4) Provides for participant eligibility and determination for the Health Home program;

(5) Provides for coverage and limitations for the Health Home program including comprehensive care management, care coordination and health promotion, comprehensive transitional care and support services;

(6) Provides for procedural requirements for the Health Home program;

(7) Provides for provider qualifications and duties for the Health Home program; and

(8) Provides for quality assurance for the Health Home program.

The Department states that negotiated rulemaking was not conducted because these proposed changes are based on a collaborative group of stakeholders set up by the Governor for the medical home initiative and that there has been extensive participation and input in meetings. A public hearing is scheduled for October 23, 2012, at 2 p.m. at the Medicaid Central Office at 3232 Elder St. in Boise. There is no fiscal impact associated with this rulemaking.

The proposed rule appears to be within the statutory authority granted to the Department in Sections 56-202(b), 56-203 and 56-253, Idaho Code.

(2) 16.03.09 - Rules Pertaining To Medicaid Basic Plan Benefits (EPSDT coverage) (Docket No. 16-0309-1206)

The Department of Health and Welfare submits notice of proposed rulemaking at IDAPA 16.03.09 - Rules Pertaining To Medicaid Basic Plan Benefits (EPSDT coverage). The Department states that the Centers for Medicare and Medicaid Services (CMS) provided guidance on federal requirements for Idaho's Early Periodic Screening Diagnosis and Treatment (EPSDT) program. According to the Department, this rulemaking reflects this guidance from CMS by adding a definition of medically necessary services for EPSDT.

The Department states that negotiated rulemaking was not conducted because the proposed changes are being made to align the state's rules with federal regulations. A public hearing is scheduled for October 22, 2012, at 2 p.m. at the Medicaid Central Office at 3232 Elder St. in Boise. There is no fiscal impact associated with this rulemaking.

The proposed rule appears to be within the statutory authority granted to the Department in Sections 56-202(b), 56-203 and 56-253, Idaho Code, and Section 1905(r) of the Social Security Act and 42 CFR Section 441.56.

(3) 16.03.10 - Rules Pertaining To Medicaid Enhanced Plan Benefits (Provider Rates of Reimbursement) (Docket No. 16-0310-1201)

The Department of Health and Welfare submits notice of proposed rulemaking at IDAPA 16.03.10 - Rules Pertaining To Medicaid Enhanced Plan Benefits (Provider Rates of Reimbursement). The Department states that the proposed rulemaking provides a process for providers to report costs incurred and for the Department to determine rates based on those reports. The Department states that this rulemaking is in response to a request by the 2012 Legislature for the Department to work with providers to determine an effective process for reporting information for evaluation of provider rates of reimbursement set by Medicaid. We contacted the Department regarding this request from the Legislature, and they responded that the Health and Welfare subcommittees made this request in response to a proposed rulemaking from 2011, Docket No. 16-0310-1101. Specifically, this rulemaking accomplishes the following:

(1) Provides for reimbursement rates for participant services based on cost surveys conducted by the Department;

(2) Lists the types of services that are reimbursed; and

(3) Revises how payments are determined for personal assistance agencies and PCS family alternate care homes in light of the new cost surveys.

The Department states that negotiated rulemaking was conducted and notice was published in the May 2, 2012, Idaho Administrative Bulletin, Vol. 12-5, page 71. A public hearing is scheduled for October 24, 2012, at 1 p.m. at the Medicaid Central Office at 3232 Elder St. in Boise. There is no fiscal impact associated with this rulemaking.

The proposed rule appears to be within the statutory authority granted to the Department in Sections 56-202(b) and 56-203, Idaho Code.

(4) 16.03.10 - Rules Pertaining To Medicaid Enhanced Plan Benefits (New Behavioral Care Units (BCU) in Nursing Facilities) (Docket No. 16-1310-1205)

The Department of Health and Welfare submits notice of temporary and proposed rulemaking at IDAPA 16.03.10 - Rules Pertaining To Medicaid Enhanced Plan Benefits (New Behavioral Care Units (BCU) in Nursing Facilities). The Department states that the proposed rulemaking implements new Behavioral Care Units (BCU) in nursing facilities and intermediate care facilities for people with intellectual disabilities and continues reimbursement methodologies and rates based on current cost reporting years. Specifically, this rulemaking accomplishes the following:

(1) Adds definitions for new types of urban and rural nursing facilities;

(2) Provides for cost limits and the development of reimbursement rates for nursing facilities for 2012 and annually thereafter;

(3) Establishes rate determination and setting for a BCU;

(4) Lists criteria for participants in a BCU;

(5) Provides for staff training and requirements in a BCU;

(6) Provides for care planning, behavioral management and discharge criteria in a BCU;

(7) Provides criteria for new BCUs, for adding a BCU to an existing nursing facility and for new owners of a facility with a BCU; and

(8) Revises the calculation of special rates of payment for qualifying residents of special care facilities and ventilator dependent residents.

The Department states that negotiated rulemaking was not conducted because the Department has held discussions with providers and stakeholders over several years to reflect an agreed upon reimbursement for BCUs. A public hearing is scheduled for October 24, 2012, at 9 a.m. at the Medicaid Central Office at 3232 Elder St. in Boise. There is no fiscal impact associated with this rulemaking.

The proposed rule appears to be within the statutory authority granted to the Department in Sections 56-202(b) and 56-203

cc: Department of Health and Welfare - Medicaid Basic Plan Benefits, Medicaid Enhanced Plan Benefits
Tamara Prisock
Cindy Brock
Sheila Pugatch
Robert Kellerman

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1205

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, 56-260 through 56-266, Idaho Code.

PUBLIC HEARING SCHEDULE: A Public hearing concerning this rulemaking will be held as follows:

Tuesday - October 23, 2012 - 2:00 p.m. MDT

Medicaid Central Office
Conference Room D-East and D-West
3232 Elder Street
Boise, ID 83705

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: following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The rule amendments in this docket are being made to address the Governor's medical home initiative that has been developed over the past two years to provide better coordination of care for eligible individuals with chronic diseases and for covered services needed. The Idaho Medicaid Health Home is Medicaid's response to a multi-payer collaborative initiative in an effort to reduce ER visits, hospital admits, and prevention of co-morbid conditions. These rules implement a patient-centered medical home model of care that will coexist with the primary care case management structure called Healthy Connections.

These changes provide for the administration of the Idaho Medicaid Health Home program, which includes Home Health Services, definitions, participant eligibility including coverage and limitations, provider qualifications, procedural requirements, reimbursement structure, and quality assurance. In addition, the Healthy Connections program structure and rules have be revised and updated to describe the relationship between the Health Home program and the Healthy Connections program.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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:

No fiscal impact to the state general fund is expected as anticipated savings from better coordination of care and reduction in service utilization will offset any additional costs.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not initiated or feasible since the changes in this rulemaking are based on a collaborative group of stakeholders set up by the Governor for the medical home initiative. There has been extensive participation in these meetings and input has been provided on the Idaho Medicaid Health Home program.

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 proposed rule, contact Cindy Brock at (208) 364-1983.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 24, 2012.

DATED this 31st day of August, 2012.

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 PROPOSED TEXT OF DOCKET NO. 16-0309-1205

399. COVERED SERVICES UNDER BASIC PLAN BENEFITS.
Individuals who are eligible for Medicaid Basic Plan Benefits are eligible for the following benefits, subject to the coverage limitations contained in these rules. Those individuals eligible for services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," are also eligible for the services covered under this chapter of rules, unless specifically exempted. (5-8-09)

01. Hospital Services. The range of hospital services covered is described in Sections 400 through 449 of these rules. (5-8-09)

a. Inpatient Hospital Services are described in Sections 400 through 406. (3-30-07)

b. Outpatient Hospital Services are described in Sections 410 through 416. (3-30-07)

c. Reconstructive Surgery services are described in Sections 420 through 426. (3-30-07)

d. Surgical procedures for weight loss are described in Sections 430 through 436. (3-30-07)

e. Investigational procedures or treatments are described in Sections 440 through 446. (3-30-07)

02. Ambulatory Surgical Centers. Ambulatory Surgical Center services are described in Sections 450 through 499 of these rules. (5-8-09)

03. Physician Services and Abortion Procedures. Physician services and abortion procedures are described in Sections 500 through 519 of these rules. (5-8-09)

a. Physician services are described in Sections 500 through 506. (3-30-07)

b. Abortion procedures are described in Sections 510 through 516. (3-30-07)

04. Other Practitioner Services. Other practitioner services are described in Sections 520 through 559 of these rules. (5-8-09)

a. Midlevel practitioner services are described in Sections 520 through 526. (3-30-07)

b. Chiropractic services are described in Sections 530 through 536. (3-30-07)

c. Podiatrist services are described in Sections 540 through 545. (3-29-12)

d. Licensed midwife (LM) services are described in Sections 546 through 552. (3-29-12)

e. Optometrist services are described in Sections 553 through 556. (3-29-12)

05. Primary Care Case Management. Primary care case management services are described in Sections 560 through 5~~6~~79 of these rules**.** (5-8-09)

a. Healthy Connections services are described in Sections 560 through 566. ( )

b. Health Home services are described in Sections 570 through 576. ( )

06. Prevention Services. The range of prevention services covered is described in Sections 5~~7~~80 through 649 of these rules. ~~(5-8-09)~~( )

~~*a. Health Risk Assessment services are described in Sections 570 through 576.* (3-30-07)~~

~~*b*~~a. Child Wellness Services are described in Sections 580 through 586. (3-30-07)

~~*c*~~b. Adult Physical Services are described in Sections 590 through 596. (3-30-07)

~~*d*~~c. Screening mammography services are described in Sections 600 through 606. (3-30-07)

~~*e*~~d. Diagnostic Screening Clinic services are described in Sections 610 through 61~~6~~4. ~~(3-30-07)~~( )

e. Additional Assessment and Evaluation services are described in Section 615. ( )

f. Health Questionnaire Assessment is described in Section 618. ( )

~~*f*~~g. Preventive Health Assistance benefits are described in Sections 620 through 626. (5-8-09)

~~*g*~~h. Nutritional services are described in Sections 630 through 636. (3-30-07)

~~*h*~~i. Diabetes Education and Training services are described in Sections 640 through 646. (3-30-07)

07. Laboratory and Radiology Services. Laboratory and radiology services are described in Sections 650 through 659 of these rules. (5-8-09)

08. Prescription Drugs. Prescription drug services are described in Sections 660 through 679 of these rules. (5-8-09)

09. Family Planning. Family planning services are described in Sections 680 through 689 of these rules. (5-8-09)

10. Substance Abuse Treatment Services. Services for substance abuse treatment are described in Sections 690 through 699 of these rules. (5-8-09)

11. Mental Health Services. The range of covered Mental Health services are described in Sections 700 through 719 of these rules. (5-8-09)

a. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (3-30-07)

b. Mental Health Clinic services are described in Sections 707 through 71~~8~~9. ~~(3-30-07)~~( )

12. Home Health Services. Home health services are described in Sections 720 through 729 of these rules. (5-8-09)

13. Therapy Services. Occupational therapy, physical therapy, and speech-language pathology services are described in Sections 730 through 739 of these rules. (5-8-09)

14. Audiology Services. Audiology services are described in Sections 740 through 749 of these rules. (5-8-09)

15. Durable Medical Equipment and Supplies. The range of covered durable medical equipment and supplies is described in Sections 750 through 779 of these rules. (5-8-09)

a. Durable Medical Equipment and supplies are described in Sections 750 through 756. (3-30-07)

b. Oxygen and related equipment and supplies are described in Sections 760 through 766. (3-30-07)

c. Prosthetic and orthotic services are described in Sections 770 through 776. (3-30-07)

16. Vision Services. Vision services are described in Sections 780 through 789 of these rules. (5-8-09)

17. Dental Services. The dental services covered under the Basic Plan are covered under a selective contract as described in Section 800 through 819 of these rules. (3-29-12)

18. Essential Providers. The range of covered essential services is described in Sections 820 through 859 of these rules. (5-8-09)

a. Rural health clinic services are described in Sections 820 through 826. (3-30-07)

b. Federally Qualified Health Center services are described in Sections 830 through 836. (3-30-07)

c. Indian Health Services Clinic services are described in Sections 840 through 846. (3-30-07)

d. School-Based services are described in Sections 850 through 856. (3-30-07)

19. Transportation. The range of covered transportation services is described in Sections 860 through 879 of these rules. (5-8-09)

a. Emergency transportation services are described in Sections 860 through 866. (3-30-07)

b. Non-emergency medical transportation services are described in Sections 870 through 876. ~~(3-30-07)~~( )

20. EPSDT Services. EPSDT services are described in Sections 880 through 889 of these rules. (5-8-09)

21. Specific Pregnancy-Related Services. Specific pregnancy-related services are described in Sections 890 through 899 of these rules. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

413. OUTPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. Review Prior to Delivery of Outpatient Services. Failure to obtain a timely review from the Department or its quality improvement organization (QIO) prior to delivery of outpatient services, listed on the select procedure and diagnosis list in the QIO Idaho Medicaid Providers Manual and the Hospital Provider Handbook, as amended, for participants who are eligible at the time of service, will result in a retrospective review. The Department

will assess a late review penalty, as outlined in Subsection 405.05 of these rules, when a review is conducted due to an untimely request. ~~(3-30-07)~~( )

02. Follow-Up for Emergency Room Patients with Chronic Conditions. Hospitals must establish procedures to refer Medicaid participants with targeted chronic diseases defined in Section 560 of these rules to an Idaho Medicaid Health Home provider, if one is available within a reasonable distance of the participant's residence. Hospitals must coordinate care of patients who already have a Health Home provider with that PCP. ( )

(BREAK IN CONTINUITY OF SECTIONS)

SUB AREA: PRIMARY CARE CASE MANAGEMENT
(Sections 560 -- 5~~6~~79)

560. HEALTHY CONNECTIONS AND IDAHO MEDICAID HEALTH HOME: DEFINITIONS.
For purposes of this Sub Area that includes Sections 560 through 579 of these rules, ~~*unless the context clearly requires otherwise,*~~ the following ~~*words and*~~ terms ~~*have the following meanings*~~ and definitions apply:
~~(3-30-07)~~( )

01. Best Practices Protocol. A regimen of proven, effective and evidence-based practices. (4-2-08)

02. Care Plan. A patient specific document that identifies health care orders for the patient and serves as a guide to care. It can either be written for an individual patient or be retrieved from a computer and individualized. ( )

0~~2~~3. Chronic Disease Management. The process of applying best practices protocol to manage a chronic disease in order to produce the best health outcomes for a participant with the targeted chronic disease. (4-2-08)

0~~3~~4. Clinic. Two (2) or more qualified medical professionals who provide services jointly through an organization for which an individual is given authority to act on its behalf. It also includes Federally Qualified Health Centers (FQHCs), Certified Rural Health Clinics, and Indian Health Clinics. (3-30-07)

0~~4~~5. Covered Services. Those medical services and supplies for which reimbursement is available under the State Plan. (3-30-07)

0~~5~~6. Grievance. The formal process by which problems and complaints related to Healthy Connections are addressed and resolved. Grievance decisions may be appealed as provided herein. (3-30-07)

07. Health Home. A primary care provider organization contracted with Medicaid to lead a team approach for chronic disease management. The Health Home provides comprehensive patient centered care management and health promotion services to patients with chronic conditions in accordance with the requirements described in section 560 through 579 of these rules and Section 1945 of the Social Security Act. ( )

08. Health Information Technology. Electronic tools utilized to securely exchange or manage health information between two or more entities. ( )

0~~6~~9. Healthy Connections. The provision of health care services through a single point of entry for the purposes of managing participant care with an emphasis on preventative and primary care and reducing inappropriate utilization of services and resulting costs. This is sometimes referred to as managed care. Healthy Connections is a primary care case management model. (4-2-08)

10. Individual or Family Supports. Community based social supports or recovery services available to assist individuals or families in need. ( )

11. **National Committee for Quality Assurance (NCQA)**. Accrediting organization which develops health care performance measurements and provides certifications of quality to health care providers. ( )

~~***07.*** ***Pay-for-Performance***. *The use of incentives to encourage and reinforce the delivery of evidence-based practices that promote better outcomes as efficiently as possible.* (4-2-08)~~

12. **Preventive Care**. Medical care that focuses on disease prevention and health maintenance. ( )

~~***08***~~**13.** **Primary Care Case Management**. The process in which a primary care provider is responsible for direct care of a participant, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the participant. (4-2-08)

~~***09***~~**14.** **Primary Care Provider (PCP)**. A qualified medical professional who contracts with Medicaid to coordinate the care of certain participants enrolled in the Healthy Connections program. ~~*(4-2-08)*~~( )

1~~0~~5. **Qualified Medical Professional**. A duly licensed physician in the following specialties: Pediatrics, Internal Medicine, Family Practice, General Practice, General Surgery, Obstetrics/Gynecology, or a physician in any other specialty who chooses to assume the function of primary care case management. It also includes nurse practitioners, and physician assistants. Licenses must be held in the state(s) where services are being rendered. (3-30-07)

16. **Quality Improvement Program**. A program of organized, ongoing, and systematic efforts to improve and assess the quality of care within a primary care provider practice or organization. ( )

17. **Quality Measures**. A measure of health care performance based on specified dimensions of care and service. ( )

~~***1***~~**18.** **Referral**. ~~*The process by which*~~ A documented communication from a participant's primary care provider (PCP) to another Medicaid provider authorizing ~~*participants gain access to those*~~ specific covered services subject to primary care case management~~, *but*~~ that are not provided by the ~~*primary care provider*~~ participant's PCP. ~~*It is the authorization for such services.*~~ ~~*(3-30-07)*~~( )

19. **Risk Factor.** A characteristic, condition, or behavior that increases the possibility of disease or injury. ( )

~~***1***~~**20.** **Targeted Chronic Disease**. ~~*One (1) of the diseases included in the chronic disease management pay-for-performance program. The specific targeted chronic diseases are diabetes, asthma, hypertension, hyperlipidemia, and depression. The Department may change the diseases included in the program after appropriate notification to PCPs.*~~ A disease identified by the Department for management under the Idaho Medicaid Health Home program. Specific conditions are identified in the Medicaid Provider Handbook available at www.idmdedicaid.com. ~~*(4-2-08)*~~( )

21. **Transitional Care**. The care or services provided by a health care provider to ensure care of the patient as they move between health care settings or between healthcare providers. ( )

561. HEALTHY CONNECTIONS: PARTICIPANT ELIGIBILITY.

~~***01.*** ***Voluntary County***. *In a county where participation in Healthy Connections is voluntary, the participant will be given an opportunity to choose a PCP. If the participant is unable to choose a provider but wishes to participate, a provider will be assigned by the Department. If a voluntary county subsequently becomes a mandatory county, provider selection and assignment will remain unchanged where possible.* (4-2-08)~~

0~~2~~1. ~~***Mandatory County***. *In a county where participation*~~ **Primary Care Case Management Enrollment**. Each participant in Idaho Medicaid is enrolled in Healthy Connections~~ *is mandatory*~~, unless the participant is granted an exemption by the Department described in Subsections 561.02.a. through 561.02.h. of this rule. Each participant must choose a PCP within the Healthy Connections program. If a participant fails to choose a PCP, one will be assigned ~~*if the participant fails to choose a participating provider after given the opportunity to do*~~

~~so~~ to the participant by the Department. ~~Members~~ Participants of the same family ~~do not have to~~ may choose ~~the same~~ different Healthy Connections providers. ~~All participants in the county are required to participate unless individually granted an exception.~~ ( )

02. ~~Exceptions~~ Exemption from Participation. An exemption from participation in ~~a mandatory county are available~~ Healthy Connections may be granted on a individual basis by the Department for a participant~~s~~ who: ~~(4-2-08)~~( )

a. ~~Have to travel more than~~ Is unable to access a Healthy Connections provider within a distance of thirty (30) miles, or within thirty (30) minutes to obtain primary care services; ~~(3-30-07)~~( )

b. Ha~~ve~~s an eligibility period that is less than three (3) months; ~~(3-30-07)~~( )

c. Ha~~ve~~s an eligibility period that is only retroactive; ~~(3-30-07)~~( )

d. ~~Are~~ Is eligible only as a Qualified Medicare Beneficiary; ~~(3-30-07)~~( )

e. Ha~~ve~~s an existing relationship with a primary care physician or clinic who is not participating ~~with the~~ in Healthy Connections; ~~or~~ ~~(3-30-07)~~( )

~~**f.** Has incompatible third party liability.~~ ~~(3-30-07)~~

~~**g**~~**f.** ~~Are~~ Is enrolled in the Medicare/Medicaid Coordinated Plan~~.~~; ~~(4-2-08)~~( )

g. Resides in a nursing facility or an ICF/ID; or ( )

h. Resides in a county where there are not an adequate number of providers to deliver primary care case management services. ( )

562. HEALTHY CONNECTIONS: COVERAGE AND LIMITATIONS.

01. Exempted Services. All services are subject to primary care case management unless specifically exempted. The following services are exempt: (3-30-07)

a. Family planning services; (3-30-07)

b. Treatment for ~~E~~emergency ~~care (as defined by the Department for the purpose of payment and performed in an emergency department)~~ medical conditions defined in Subsection 010.23 of these rules; and ~~(3-30-07)~~( )

c. Hospital admissions subsequent to an emergency room visit provided that the patient's discharge is coordinated with a PCP; ( )

~~**c**~~**d.** Dental care; (4-2-08)

~~**d**~~**e.** Podiatry (performed in the office); (3-30-07)

~~**e**~~**f.** Audiology (hearing tests or screening, does not include ear/nose/throat services); (3-30-07)

~~**f**~~**g.** Optical/Ophthalmology/Optometrist services (performed in the office); (3-30-07)

~~**g**~~**h.** Chiropractic (performed in the office); (3-30-07)

~~**h**~~**i.** Pharmacy (prescription drugs only); (3-30-07)

~~**i**~~**j.** Nursing home; (3-30-07)

~~j~~k. ICF/ID services; (3-30-07)

~~k~~l. Immunizations (not requiring an office visit); (4-2-08)

~~l~~m. Flu shots and/or pneumococcal vaccine (not requiring an office visit); (3-30-07)

~~m~~n. Diagnosis and/or treatment for sexually transmitted diseases; (3-30-07)

~~n~~o. One screening mammography per calendar year for women age forty (40) or older; (3-30-07)

~~o~~p. Indian Health Clinic/638 Clinic services provided to individuals eligible for Indian Health Services; (4-2-08)

~~p~~q. In-home services, known as Personal Care Services and Personal Care Services Case Management; (4-2-08)

~~q~~r. Laboratory services, including pathology; (4-2-08)

~~r~~s. Anesthesiology services; (3-29-12)

~~s~~t. Radiology services; ~~and~~ ~~(3-29-12)~~( )

~~t~~u. Services rendered at an Urgent Care Clinic when the participant's PCP's office is closed~~.~~; ~~(3-29-12)~~( )

v. School-based services; ( )

w. Services managed directly by the Department, as defined in the provider handbook for those services at www.idmedicaid.com; and ( )

x. Pregnancy related services provided by an obstetrician or gynecologist not enrolled as a Healthy Connections provider. ( )

02. Change in Services That Require a Referral. The Department may change the services that require a referral after appropriate notification of Medicaid eligible individuals and providers. (3-30-07)

563. HEALTHY CONNECTIONS: PROCEDURAL REQUIREMENTS.

01. Primary Care Case Management. Under the Healthy Connections model of managed care, each participant obtains medical services through a PCP. This provider either provides the needed service, or makes a referral for needed services. This management function neither reduces nor expands the scope of covered services. (4-2-08)

a. Referrals. The primary care provider is responsible for making all reasonable efforts to monitor and manage the participant's care, providing primary care services, and making referrals for services when medically necessary. All services not specifically exempted in Section 562 of these rules require receipt of a referral prior to delivery of services. Services that require a referral, but are provided without a referral ~~will~~ are not ~~be paid~~ covered. All referrals must be documented in the participant's patient record. ~~(3-30-07)~~( )

b. Changing PCP~~s~~. If a participant is dissatisfied with his PCP, he may change providers ~~effective the first day of any month~~ by contacting his designated Healthy Connections Representative ~~to do so no later than fifteen~~ at least ten (1~~5~~0) days ~~in advance~~ prior to the end of the month. The change is effective the first day of the following month. This advance notice requirement may be waived by the Department. ~~(4-2-08)~~( )

c. Changing Service Areas. A ~~P~~participant~~s~~ who move~~s~~ from the area where ~~they are~~ he is enrolled must ~~disenroll in the same manner as provided in the preceding paragraph for changing PCPs, and may obtain a referral from their PCP pending the transfer. Such referrals are valid not to exceed thirty (30) days~~ contact his

designated Healthy Connections Representative to disenroll from his current PCP and enroll with a new PCP in the area where moving. Enrollment with the new PCP is effective the first day of the month following the request. ~~(4-2-08)~~( )

02. Problem Resolution. (3-30-07)

a. ~~*Intent.*~~ To help assure the success of Healthy Connections, the Department ~~*intends to*~~ provides a mechanism for timely and personal attention to problems and complaints related to the program. ~~(3-30-07)~~( )

b. ~~*Local Program Representative.*~~ To facilitate problem resolution, ~~*each area*~~ the Department will have a designated representative who will receive and attempt to resolve all complaints and problems related to the program and function as a liaison between participants and providers. It is anticipated that most problems and complaints will be resolved informally at this level. ~~(4-2-08)~~( )

c. ~~*Registering a Complaint. Both*~~ A participant~~s and~~ or a provider~~s~~ may register a complaint or notify the Department of a problem related to Healthy Connections either ~~*by*~~ in writing, electronically, or by telephon~~ing~~e to the ~~*local program*~~ designated representative. The ~~*health*~~ designated representative will attempt to resolve conflicts and disputes whenever possible and refer the complainant to alternative forums where appropriate. ~~(3-30-07)~~( )

d. ~~*Grievance.*~~ If a participant or provider is not satisfied with the resolution of a problem or complaint addressed by the ~~*program*~~ designated representative, he may file a formal grievance in writing to the representative. The manager of the managed care program may, where appropriate, refer the matter to a review committee designated by the Department to address issues such as quality of care or medical necessity. However, such decisions are not binding on the Department. The Department will respond in writing to grievances within thirty (30) days of receipt. ~~(3-30-07)~~( )

e. ~~*Appeal.*~~ Decisions in response to grievances may be appealed. Appeals ~~*by participants*~~ are ~~*considered as fair hearings and appeals by providers as contested cases under the Rules Governing Contested Case Proceedings and Declaratory Rulings,*~~ governed by the requirements of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," and must be filed ~~*in accordance with*~~ according to the provisions of that chapter. ~~(3-30-07)~~( )

~~***03. Chronic Disease Management Registration.** A participating PCP must initially register each participant eligible for chronic disease management reimbursement with the Department. (4-2-08)*~~

~~***04. Chronic Disease Management Reporting.** A participating PCP must annually report on all identified quality indicators for each targeted chronic disease that he seeks reimbursement as specified in the provider agreement. The reporting schedule is established by the Department in the provider agreement. (4-2-08)*~~

564. HEALTHY CONNECTIONS: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Participation Qualifications. Primary care case management services may be provided by qualified medical professionals, licensed to practice in the state where services are being rendered. (3-30-07)

02. Provider Participation Conditions and Restrictions. (3-30-07)

a. Quality of Services. Each ~~P~~provider must: ( )

i. ~~m~~Maintain and provide services in accordance with community standards of care~~. Provider must~~; ( )

ii. ~~e~~Exercise his best efforts to effectively control utilization of services~~. Providers must~~; and ( )

iii. ~~p~~Provide twenty-four (24) hour coverage by telephone to assure participant access to services. ~~(3-30-07)~~( )

b. Provider Agreements. Each ~~P~~provider~~s~~ participating in primary care case management must:

( )

i. ~~s~~Sign an agreement~~. Clinics may sign an agreement on behalf of their qualified medical professionals.~~.; ( )

ii. Enroll with the Department all primary care clinic locations as Healthy Connections service locations; and ( )

iii. ~~Providers participating in the chronic disease management pay for performance program must s~~Sign an addendum to the primary care case management provider agreement when participating in the Idaho Medicaid Health Home program. ~~(4-2-08)~~( )

c. Patient Limits. A ~~P~~provider~~s~~ may limit the number of participants ~~they wish~~ to manage. Subject to this limit, the provider must accept all participants who either elect or are assigned to the provider, unless disenrolled in accordance with Subsection 564.02.d. of this rule. A ~~P~~provider~~s~~ may change the~~ir~~ participant limit effective the first day of any month. ~~by written request~~ The PCP must make the request in writing to the Department thirty (30) days prior to the effective date of the change. This advance notice ~~R~~requirement maybe waived by the Department. ~~(3-30-07)~~( )

d. Disenrollment. ~~Instances may arise where~~ When the provider-patient relationship breaks down due to failure of the participant to follow the ~~plan of~~ care plan or for other reasons~~. Accordingly~~, a provider may choose to withdraw as the participant's primary care provider effective the first day of any month. ~~by written notice to~~ The PCP must notify in writing, both the participant and the Department thirty (30) days prior to the date of withdrawal. This advance notice requirement may be waived by the Department. ~~(3-30-07)~~( )

e. Record Retention. Each ~~P~~provider~~s~~ must: ( )

i. ~~r~~Retain patient and financial records and provide the Department access to those records for a minimum of six (6) years from the date of service~~.~~.; ( )

ii. Upon the reassignment of a participant to another PCP, the provider must transfer (if a request is made) a copy of the patient's medical record to the new PCP~~. Provider must also~~; and ( )

iii. ~~d~~Disclose information required by Subsection 205.01 of these rules, when applicable. ~~(4-2-08)~~( )

f. Termination or Amendment of Provider Agreements. The Department may terminate a provider's agreement as provided in Subsection 205.03 of these rules. An agreement may be amended for the same reasons. (3-30-07)

565. HEALTHY CONNECTIONS: PROVIDER REIMBURSEMENT.

01. Case Management Fee. Reimbursement is as follows: (4-2-08)

a. A PCP~~s will be~~ is paid a case management fee for primary care case management services based on the level of each participant's health care needs~~ and the PCP's availability~~. ~~(3-29-12)~~( )

b. A PCP~~s~~ enrolled in the ~~chronic disease management pay for performance~~ Idaho Medicaid Health Home program ~~will be~~ is paid a~~n enhanced~~ chronic disease case management fee. ~~(4-2-08)~~( )

c. The amount of the fee~~s~~ is determined by the Department. ~~(3-29-12)~~( )

d. The amount of the fee is fixed and the same for all participating PCPs. (4-2-08)

02. Primary Care Case Management. Reimbursement is based on: (3-29-12)

a. The number of participants enrolled ~~under~~ with the provider on the first day of each month

multiplied by the amount of the case management fee established for participants enrolled in the Basic Plan Benefit package; ~~(3-29-12)~~( )

b. The number of participants enrolled ~~under~~ with the provider on the first day of each month, multiplied by the amount of the case management fee established for participants enrolled in the Enhanced Plan Benefit package; and ~~(3-29-12)~~( )

c. ~~The amount of the case management fee is increased by fifty cents ($.50) per participant~~ An incentive payment is added per participant to the primary care case management fee in Subsection 565.01.a. of this rule when the PCP's ~~office~~ offers extended hours of service in one (1) of the following ways: ( )

i. The number of hours the PCP's office is available for delivery of service to participants equals ~~to~~ or exceed~~ing~~s forty-six (46) hours per week. The ~~amount of~~ extended hours must be verified by and on file with the Department prior to an increase to the monthly case management fee ~~generation for the increase to be paid.~~; or ~~(3-29-12)~~( )

ii. The PCP has electronic health records available and accessible for delivery of services at a nearby service location that is within the same Healthy Connections provider organization and makes services available to the participant at lease forty-six (46) hours per week. The alternate location and extended hours must be verified by and on file with the Department prior to an increase to the monthly case management fee. ( )

d. The number of participants enrolled with an Idaho Medicaid Health Home provider on the first day of the month for services described in Section 572 these rules, multiplied by the case management fee established per participant enrolled in that program. ( )

~~**03. Chronic Disease Management.** Reimbursement is based on:~~ ~~(4-2-08)~~

~~**a.** The number of participants who have a targeted chronic disease multiplied by the amount of the enhanced case management fee for patient identification; and~~ ~~(4-2-08)~~

~~**b.** The number of instances that the PCP achieved Department specified best practices protocol for the disease being managed multiplied by the amount of the enhanced case management fee for reported quality indicators.~~ ~~(4-2-08)~~

566. HEALTHY CONNECTIONS: QUALITY ASSURANCE.
The Department will establish performance measurements to evaluate the effectiveness of ~~Chronic Disease Management~~ the primary care case management programs. The performance measurements will be reviewed at least annually and adjusted as necessary to provide quality assurance. ~~(4-2-08)~~( )

567. -- 569. (RESERVED)

SUB AREA: PREVENTION SERVICES
(Sections 570 -- 649)

[SECTION 570 MOVED TO SECTION 618]

570. IDAHO MEDICAID HEALTH HOME: DEFINITIONS.
For purposes of the Idaho Medicaid Health Home program, the terms and definitions in Section 560 of these rules apply. ( )

571. IDAHO MEDICAID HEALTH HOME: PARTICIPANT ELIGIBILITY.

01. Eligibility. A Medicaid participant diagnosed with two (2) targeted chronic diseases, or one (1) targeted chronic disease and one (1) or more risk factors is eligible for enrollment in the Idaho Medicaid Health Home program. ( )

02. Eligibility Determination. A participant who meets the diagnostic criteria for health home eligibility is identified by the PCP to the Department. The Department will utilize claims data and other documentation as needed to verify the participant is eligible for Idaho Medicaid Health Home services. ( )

572. IDAHO MEDICAID HEALTH HOME: COVERAGE AND LIMITATIONS.
The following services are covered for an eligible participant assigned to a Health Home provider: ( )

01. Comprehensive Care Management. A Health Home provider must develop and implement a patient-centered care plan based on an individual's health risk assessment. The care plan must describe how the Health Home provider will coordinate clinical care with other providers as well as non-clinical health care related needs and services. ( )

02. Care Coordination and Health Promotion. A Health Home provider must: ( )

a. Coordinate the participant's care by sharing clinical information relevant to patient care with other providers; ( )

b. Provide educational information and information about health care resources to the participant; ( )

c. Have ongoing communication with the participant to encourage compliance with prescribed treatment; and ( )

d. Other activities necessary to facilitate improved health outcomes for the participant. ( )

03. Comprehensive Transitional Care. A Health Home provider must: ( )

a. Receive relevant medical information from and share relevant medical information with inpatient facilities to foster a coordinated approach to preventing avoidable readmissions; and ( )

b. Review and update care plans after unplanned admissions to adjust care coordination and management activities to address identifiable causes for the admission. ( )

04. Individual, Family, Community, and Social Support Services. A Health Home provider must: ( )

a. Coordinate care in a manner that effectively utilizes available individual and family supports to improve and maintain the health of the participant; and ( )

b. Provide information on available community and social support services that aid in promoting healthy behaviors and reducing physical and mental health risk factors. ( )

573. IDAHO MEDICAID HEALTH HOME: PROCEDURAL REQUIREMENTS.

01. Provider Agreement. A Health Home provider must sign an addendum to the primary care case management provider agreement which identifies the location of the Health Home and other requirements necessary to meet the Health Home service requirements in these rules. ( )

02. Data Reporting. Health Home providers must report data to the Department on a periodic basis in keeping with schedules outlined in the provider handbook and the terms of the Health Homes provider agreement. ( )

03. Quality Improvement Program. A provider must establish a continuous quality improvement program directed towards improving care for patients with chronic conditions. ( )

574. IDAHO MEDICAID HEALTH HOME: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Infrastructure and Health Home Assessment. A prospective Health Home provider must complete a Health Home practice assessment in cooperation with the Department to determine the ability of the provider to provide the required services in keeping with a patient-centered medical home model. This assessment must demonstrate that the provider; ( )

a. Has identified the qualified medical professionals and other resources available to provide Health Home services; ( )

b. Has the ability to utilize health information technology to coordinate and facilitate communication of health information and to link to services; ( )

c. Is able to submit clinical and practice transformation data within six (6) months of the date the provider agreement is signed; and ( )

d. Has a chronic disease patient registry in place within three (3) months of the date the provider agreement is signed. ( )

02. Qualifications. An Idaho Medicaid Health Home provider must: ( )

a. Possess a current NCQA patient-centered medical home level one (1) certification, or demonstrate that the provider is actively pursuing that recognition. A provider that does not achieve this NCQA certification within two (2) years of the initiation date of their Idaho Medicaid Health Home provider agreement will be terminated as a Health Home provider for non-compliance with the provider agreement; ( )

b. Be enrolled as a Healthy Connections primary care provider (PCP); ( )

c. Sign an addendum to their primary care provider agreement which identifies the location of the enrolled site and indicates reporting schedule and quality measurement requirements;. ( )

d. Have qualified medical professionals, licensed to practice in the state where services are being rendered; and ( )

e. Maintain office hours that allow enhanced access to care as described in Section 565.02 of these rules. ( )

03. Provider Duties. A Health Home provider must provide or coordinate the following elements of Health Home services: ( )

a. Care Plan. Develop a patient-centered care plan for each participant that coordinates and integrates both clinical and non-clinical health care related needs and services; ( )

b. Chronic Disease Management. Provide access to chronic disease management, including self-management support to the participant and the participant's family; ( )

c. Individual, Family, and Community Supports. Facilitate access to individual, family, and community supports outlined in the provider's agreement. ( )

d. Mental Health & Substance Abuse Services. Facilitate access to mental health and substance abuse services. ( )

e. Preventive Care. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance abuse disorders. ( )

f. Quality Improvement Program. Establish a continuous quality improvement program and report on quality improvement measures outlined in the provider agreement. ( )

g. Quality of Services. Maintain and provide quality services for each Home Health participant.

( )

h. Transitional Care. Coordinate and provide access to comprehensive care management and transitional care from and to inpatient settings and from a pediatric to an adult system of health care. ( )

575. (RESERVED)

576. IDAHO MEDICAID HEALTH HOME: QUALITY ASSURANCE.
The Department will establish performance measurements to evaluate the effectiveness of the Idaho Medicaid Health Home program through the collection and reporting of quality measures as specified in Section 1945 of the Social Security Act. ( )

57~~1~~7. -- 579. (RESERVED)

SUB AREA: PREVENTION SERVICES
(Sections 5~~7~~80 -- 649)

(BREAK IN CONTINUITY OF SECTIONS)

616. -- 61~~9~~7. (RESERVED)

~~570~~618. HEALTH QUESTIONNAIRE.
The Health Questionnaire assesses the general health status and health behaviors of a participant. The information collected is used to provide customized health education to the participant. The Health Questionnaire is administered at initial program entry and at periodic intervals thereafter. Participant responses to the issues addressed in the Health Questionnaire may identify a participant's interest in the Preventive Health Assistance benefits described in Section 620 of these rules. (3-30-07)

619. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1206

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, 56-260 through 56-266, Idaho Code, Section 1905(r) of the Social Security Act, and 42 CFR Section 441.56.

PUBLIC HEARING SCHEDULE: A Public hearing concerning this rulemaking will be held as follows:

Monday, October 22, 2012 2:00 p.m. MDT
Medicaid Central Office Conference Room East 3232 Elder Street Boise, ID 83705

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: following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The Centers for Medicare and Medicaid Services (CMS) provided guidance regarding the federal requirements for EPSDT coverage based on its review of Idaho's Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) program. This rule change reflects direction from CMS and adds a definition of medically necessary services for EPSDT.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: 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. N/A

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted nor feasible because the changes are being made to align the state's rules with federal regulations.

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 proposed rule, contact Cindy Brock at (208) 364-1983.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 24, 2012.

DATED this 29th day of August, 2012.

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

THE FOLLOWING IS THE PROPOSED TEXT FOR DOCKET NO. 16-0309-1206

880. ~~*(RESERVED)*~~ EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES: DEFINITION.
Medically necessary services for eligible Medicaid participants under the age of twenty-one (21) are health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act (SSA) necessary to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan. Services must be considered safe, effective, and meet acceptable standards of medical practice. ( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1201

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Wednesday - October 24, 2012
1:00 p.m. MDT

Medicaid Central Office
Conference Room East
3232 Elder Street
Boise, ID 83705

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 a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The 2012 Legislature requested the Department work with providers to determine an effective process for reporting and providing information in an effective manner for evaluation of provider rates of reimbursement set by Medicaid that is not already based on another established rate methodology. These proposed rules provide a process for providers to report costs incurred and for the Department to determine rates based on those reports.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

The changes in this rulemaking are meant to be budget neutral and have no fiscal impact to the state general fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 2, 2012, Idaho Administrative Bulletin, Vol. 12-5, page 71.

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 proposed rule, contact Sheila Pugatch at (208) 364-1817.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 24, 2012.

DATED this 29th day of August, 2012.

Tamara Prisock
DHW - Administrative Procedures Section
Boise, ID 83720-0036
phone: (208) 334-5564

450 W. State Street - 10th Floor
P.O. Box 83720
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0310-1201

036. GENERAL REIMBURSEMENT.

01. Long-Term Care Facility Payment. Long-term care facilities will be reimbursed the lower of their customary charges, their actual reasonable costs, or the standard costs for their class as set forth in the Provider Reimbursement Manual, but the upper limits for payment must not exceed the payment which would be determined as reasonable costs using the Title XVIII Medicare standards and principles. (3-19-07)

02. Individual Provider Payment. The Department will not pay the individual provider more than the lowest of: (3-19-07)

a. The provider's actual charge for service; or (3-19-07)

b. The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or (3-19-07)

c. The Medicaid upper limitation of payment on those services, minus the Medicare payment, where a participant is eligible for both Medicare and Medicaid. The Department will not reimburse providers an amount in excess of the amount allowed by Medicaid, minus the Medicare payment. (3-19-07)

~~***03. Payment for Therapy Services.*** *The fees for physical therapy, occupational therapy, and speech-language pathology services include the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the client for the use of such equipment.* ***(4-2-08)***~~

~~***037. 038. (RESERVED)***~~

037. GENERAL REIMBURSEMENT: PARTICIPANT SERVICES.
The Department will evaluate provider reimbursement rates that comply with 42 U.S.C. 1396a(a)(30)(A). This evaluation will assure payments are consistent with efficiency, economy, and quality of care and safeguards against unnecessary utilization of care and services. Reimbursements will be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. ( )

01. Review Reimbursement Rates. The Department will review provider reimbursement rates and conduct cost surveys when an access or quality indicator reflects a potential access or quality issue described in Subsections 037.02 and 037.03 of this rule. ( )

02. Access. The Department will review annual statewide and regional access reports by service type comparing the previous twelve (12) months to the base-line year of State Fiscal Year 2012. The following measures will be used to determine when there is potential for access issues. ( )

a. Compare the change in total number of provider locations for service type to the change in eligible participants; or ( )

b. When participant complaints and critical incidence logs reveal outcomes that identify access issues for a service type. ( )

03. Quality. The Department will review quality reports required by each program used to monitor for patterns indicating an emerging quality issue. ( )

04. Cost Survey. The Department will survey one hundred percent (100%) of providers. Cost surveys

are unaudited, but providers that refuse or fail to respond to the periodic state surveys may be disenrolled as a Medicaid provider. The Department will derive reimbursement rates using direct care staff costs, employment related expenditures, program related costs, and indirect general and administrative costs in the reimbursement methodology, when these costs are incurred by a provider. The Department will conduct cost surveys customized for each of the services defined in Section 038 of these rules. ( )

a. Wage rates will be used in the reimbursement methodology when the expenditure is incurred by the provider type executing the program. Wages will be identified in the Bureau of Labor Statistics website at www.bls.gov when there is a comparable occupation title for the direct care staff. When there is no comparable occupation title for the direct care staff, then a weighted average hourly rate methodology will be used. ( )

b. For employer related expenditures: ( )

i. The Bureau of Labor Statistics's report for employer costs per hour worked for employee compensation and costs as a percent of total compensation for Mountain West Divisions will be used to determine the incurred employer related costs by each provider type. The website for access to this report is at www.bls.gov. ( )

ii. The Internal Revenue Service employer cost for social security benefit and Medicare benefit will be used to determine the incurred employer related costs by provider type. The website for access to this information is at www.irs.gov. ( )

c. Cost surveys to collect indirect general, administrative, and program related costs will be used when these expenditures are incurred by the provider type executing the program. The costs will be ranked by costs per provider, and the Medicaid cost used in the reimbursement rate methodology will be established at the seventy-fifth percentile in order to efficiently set a rate. ( )

038. GENERAL REIMBURSEMENT: TYPES OF PARTICIPANT SERVICES.
The following types of services are reimbursed as provided in Section 037 of these rules. ( )

01. Payment for Enhanced Outpatient Mental Health Services. The fees for outpatient mental health services described in Section 110 of these rules. ( )

02. Psychosocial Rehabilitative Services (PSR). The fees for psychosocial rehabilitative services (PSR) described in Section 120 of these rules. ( )

03. Personal Care Services. The fees for personal Care Services (PCS) described in Section 300 of these rules. ( )

04. Aged and Disabled Waiver Services. The fees for personal care services (PCS) described in Section 320 of these rules. ( )

05. Children's Waiver Services. The fees for children's waiver services described in Section 680 of these rules. ( )

06. Adults with Developmental Disabilities Waiver Services. The fees for adults with developmental disabilities waiver services described in Section 700 of these rules. ( )

07. Service Coordination. The fees for service coordination described in Section 720 of these rules. ( )

08. Therapy Services. The fees for physical therapy, occupational therapy, and speech-language pathology services described in Section 215 of these rules include the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the client for the use of such equipment. ( )

(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*~~. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department.
~~*(3-21-12)*~~( )

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*~~ Department or its contractor 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 307.0~~7~~8 of ~~*these*~~ this rule~~s~~.
~~*(3-19-07)*~~( )

03. Weighted Average Hourly Rate~~s~~ Methodology. 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. Payment for personal assistance agency services will be paid according to rates established by the Department.
~~*(3-4-11)*~~( )

a. The Department will establish Personal Assistance Agency rates for personal assistance services based on the WAHR. ~~*For State Fiscal Year 2012, this rate will only be adjusted if the prevailing hourly rate for comparable positions is less than the rate paid during State Fiscal Year 2011.*~~

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

~~*(3-21-12)*~~( )

b. ~~*Beginning with State Fiscal Year 2013, 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, t*~~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.
~~*(3-21-12)*~~( )

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.*~~ The Department will survey one hundred percent (100%) of personal care service providers. Cost surveys are unaudited, but a provider that refuses or fails to respond to the periodic state surveys may be disenrolled as a Medicaid provider. The Department will derive reimbursement rates using direct care staff costs, employment related expenditures, program related costs, and indirect general and administrative costs in the reimbursement methodology, when these costs are incurred by a provider.
~~*(3-4-11)*~~( )

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*~~ Department or its contractor. ~~*(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*~~ Department or its contractor. ~~*(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*~~ Department or its contractor. ~~*(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. ~~*Beginning with State Fiscal Year 2013, 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 supplemental component)	=	$ amount/week

~~*(3-21-12)*~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1205

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 1, 2012.

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, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

PUBLIC HEARING SCHEDULE: A Public hearing concerning this rulemaking will be held as follows:

Wednesday - October 24, 2012
9:00 a.m. MDT

Medicaid Central Office
Conference Room East
3232 Elder Street
Boise, ID 83705

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:

The changes to these rules implement new Behavioral Care Units (BCU) in nursing facilities (NFs) and intermediate care facilities for people with intellectual disabilities (ICFs/ID). The BCUs are designed to enhance a nursing facility resident's quality of life, quality of care, and enhance their functional and cognitive status and safety. Other changes in this docket continue reimbursement methodologies and rates based on current cost reporting years.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(a) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

These rule changes provide for the health and safety of individuals living in NFs and ICFs/ID and confer a benefit by providing quality care and services to participants living in these facilities.

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: None.

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. N/A

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the Department has held discussions with providers and stakeholders over several years to reflect an agreed upon reimbursement for Behavioral Care Units. This rulemaking addresses the issues from those meetings.

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 October 24, 2012.

DATED this 5th day of September, 2012.

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 OF DOCKET NO. 16-0310-1205

011. DEFINITIONS: E THROUGH K.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Educational Services. Services which are provided in buildings, rooms or areas designated or used as a school or as educational facilities; which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students; and which are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations; are not related services**;** and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. (3-19-07)

02. Eligibility Rules. IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-19-07)

03. Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (3-19-07)

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. (3-19-07)

b. Serious impairment to bodily functions. (3-19-07)

c. Serious dysfunction of any bodily organ or part. (3-19-07)

04. Enhanced Plan. The medical assistance benefits included under this chapter of rules. (3-19-07)

05. EPSDT. Early and Periodic Screening Diagnosis and Treatment. (3-19-07)

06. Equity. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

07. Facility. Facility refers to a hospital, nursing facility, or an intermediate care facility for persons with intellectual disabilities. (3-19-07)

a. "Free-standing and Urban Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.b. or 011.07.h. of this rule, and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. (10-1-12)T

~~a~~b. "Free-standing Nursing Facility" means a nursing facility that is not owned, managed, or operated by, nor is otherwise a part of a licensed hospital. (3-19-07)

~~b~~c. "Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)" means an entity as defined in Subsection 011.~~29~~30 in this rule. ~~(3-19-07)~~(10-1-12)T

~~c~~d. "Nursing Facility (NF)" means a facility licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare patients. (3-19-07)

e. "Rural Hospital-based Provider" means a hospital-based nursing facility not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (10-1-12)T

f. "Rural Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.e., and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. (10-1-12)T

~~d~~g. Skilled Nursing Facility" means a nursing facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and federally certified as a "Nursing Facility" under Title XVIII. (3-19-07)

~~e~~h. "Urban Hospital-~~B~~based Nursing Facilit~~ies~~y" means a hospital-based nursing facilit~~ies~~y located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. ~~(3-19-07)~~(10-1-12)T

08. Fiscal Intermediary Agency. An entity that provides services that allow the participant receiving personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing, training, and dismissing his personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered. (5-8-09)

09. Fiscal Year. An accounting period that consists of twelve (12) consecutive months. (3-19-07)

10. Forced Sale. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (3-19-07)

11. Funded Depreciation. Amounts deposited or held which represent recognized depreciation. (3-19-07)

12. Generally Accepted Accounting Principles (GAAP). A widely accepted set of rules, conventions, standards, and procedures for reporting financial information as established by the Financial Standards Accounting Board. (3-19-07)

13. Goodwill. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is a nonallowable, nonreimbursable expense. (3-19-07)

14. Healthy Connections. The primary care case management model of managed care under Idaho Medicaid. (3-19-07)

15. Historical Cost. The actual cost incurred in acquiring and preparing an asset for use, including

feasibility studies, architects' fees, and engineering studies. (3-19-07)

16. **ICF/ID Living Unit**. The physical structure that an ICF/ID uses to house patients. (3-19-07)

17. **Improvements**. Improvements to assets which increase their utility or alter their use. (3-19-07)

18. **Indirect Care Costs**. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (3-19-07)

a. Activities; (3-19-07)

b. Administrative and general care costs; (3-19-07)

c. Central service and supplies; (3-19-07)

d. Dietary (non-"raw food" costs); (3-19-07)

e. Employee benefits associated with the indirect salaries; (3-19-07)

f. Housekeeping; (3-19-07)

g. Laundry and linen; (3-19-07)

h. Medical records; (3-19-07)

i. Other costs not included in direct care costs, or costs exempt from cost limits; and (3-19-07)

j. Plant operations and maintenance (excluding utilities). (3-19-07)

19. **Inflation Adjustment**. The cost used in establishing a nursing facility's prospective reimbursement rate is indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. (3-19-07)

20. **Inflation Factor**. For use in establishing nursing facility prospective rates, the inflation factor is the Skilled Nursing Facility Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. The national index is used when there is no state or regional index. (3-19-07)

21. **In-State Care**. Medical services provided within the Idaho border or in counties bordering Idaho are considered to be in-state, excluding long term care. (3-19-07)

22. **Inspection of Care Team (IOCT)**. An interdisciplinary team which provides inspection of care in intermediate care facilities for persons with intellectual disabilities approved by the Department as providers of care for eligible medical assistance participants. Such a team is composed of: (3-19-07)

a. At least one (1) registered nurse; and (3-19-07)

b. One (1) Qualified Intellectual Disabilities Professional (QIDP); and when required, one (1) of the following: (3-19-07)

i. A consultant physician; or (3-19-07)

ii. A consultant social worker; or (3-19-07)

iii. When appropriate, other health and human services personnel responsible to the Department as

employees or consultants. (3-19-07)

23. Instrumental Activities of Daily Living (IADL). Those activities performed in supporting the activities of daily living, including, but not limited, to managing money, preparing meals, shopping, light housekeeping, using the telephone, or getting around in the community. (3-19-07)

24. Interest. The cost incurred for the use of borrowed funds. (3-19-07)

25. Interest on Capital Indebtedness. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are reported under property costs. (3-19-07)

26. Interest on Working Capital. The costs incurred for borrowing funds which will be used for "working capital" purposes. These costs are reported under administrative costs. (3-19-07)

27. Interest Rate Limitation. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/ID facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (+1%) at the date the loan is made. (3-19-07)

28. Interim Reimbursement Rate (IRR). A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (3-19-07)

29. Intermediary. Any organization that administers the Title XIX and Title XXI program; in this case the Department of Health and Welfare. (3-19-07)

30. Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). An entity licensed as an ICF/ID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (3-19-07)

31. Keyman Insurance. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. Premiums related to keyman insurance are not allowable. (3-19-07)

012. DEFINITIONS: L THROUGH O.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Lease. A contract arrangement for use of another's property, usually for a specified time period, in return for period rental payments. (3-19-07)

02. Leasehold Improvements. Additions, adaptations, corrections, etc., made to the physical components of a building or construction by the lessee for his use or benefit. Such additions may revert to the owner. Such costs are usually capitalized and amortized over the life of the lease. (3-19-07)

03. Legal Representative. A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. (3-19-07)

04. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (3-19-07)

05. Licensed Bed Capacity. The number of beds which are approved by the Licensure and Certification Agency for use in rendering patient care. (3-19-07)

06. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (3-19-07)

07. Lower of Cost or Charges. Payment to providers (other than public providers furnishing such

services free of charge or at nominal charges to the public) is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers which furnish services free of charge or at a nominal charge are reimbursed fair compensation; which is the same as reasonable cost. (3-19-07)

08. MAI Appraisal. An appraisal which conforms to the standards, practices, and ethics of the American Institute of Real Estate Appraisers and is performed by a member of the American Institute of Real Estate Appraisers. (3-19-07)

09. Major Movable Equipment. Major movable equipment means such items as beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are: (3-19-07)

a. A relatively fixed location in the building; (3-19-07)

b. Capable of being moved, as distinguished from building equipment; (3-19-07)

c. A unit cost of five thousand dollars ($5000) or more; (3-19-07)

d. Sufficient size and identity to make control feasible by means of identification tags; and (3-19-07)

e. A minimum life of three (3) years. (3-19-07)

10. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-19-07)

11. Medicaid. Idaho's Medical Assistance Program. (3-19-07)

12. Medicaid Related Ancillary Costs. For the purpose of these rules, those services provided in nursing facilities considered to be ancillary by Medicare cost reporting principles. Medicaid related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid residents by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid related ancillaries. (3-19-07)

13. Medical Care Treatment Plan. The problem list, clinical diagnosis, and treatment plan of care administered by or under the direct supervision of a physician. (3-19-07)

14. Medical Necessity (Medically Necessary). A service is medically necessary if: (3-19-07)

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (3-19-07)

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly. (3-19-07)

c. Medical services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (3-19-07)

15. Medical Supplies. Items excluding drugs and biologicals and equipment furnished incident to a physician's professional services commonly furnished in a physician's office or items ordered by a physician for the treatment of a specific medical condition. These items are generally not useful to an individual in the absence of an illness and are consumable, nonreusable, disposable, and generally have no salvage value. Surgical dressings, ace bandages, splints and casts, and other devices used for reduction of fractures or dislocations are considered supplies. (3-19-07)

16. Medicare Savings Program. The program formerly known as “Buy-In Coverage,” where the state pays the premium amount for participants eligible for Medicare Parts A and B of Title XVIII. (3-19-07)

17. **Minimum Data Set (MDS)**. A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The version of the assessment document used for rate setting is version 2.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary. (3-19-07)

18. **Minor Movable Equipment**. Minor movable equipment includes such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, buckets, etc. Oxygen concentrators used in lieu of bottled oxygen may, at the facility's option, be considered minor movable equipment with the cost reported as a medical supply. The general characteristics of this equipment are: (3-19-07)

a. No fixed location and subject to use by various departments of the provider's facility; (3-19-07)

b. Comparatively small in size and unit cost under five thousand dollars ($5000); (3-19-07)

c. Subject to inventory control; (3-19-07)

d. Fairly large quantity in use; and (3-19-07)

e. A useful life of less than three (3) years. (3-19-07)

19. **Necessary**. The purchase of goods or services that is required by law, prudent management, and for normal, efficient and continuing operation of patient related business. (3-19-07)

20. **Negotiated Service Agreement (NSA)**. The plan reached by the resident and his representative, or both, and the facility or certified family home based on the assessment, physician or authorized provider's orders, admissions records, and desires of the resident. The NSA must outline services to be provided and the obligations of the facility or certified family home and the resident. (3-19-07)

21. **Net Book Value**. The historical cost of an asset, less accumulated depreciation. (3-19-07)

22. **New Bed**. Subject to specific exceptions stated in these rules, a bed is considered new if it adds to the number of beds for which a nursing facility is licensed on or after July 1, 1999. (3-19-07)

23. **Nominal Charges**. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the related services. (3-19-07)

24. **Nonambulatory**. Unable to walk without assistance. (3-19-07)

25. **Nonprofit Organization**. An organization whose purpose is to render services without regard to gains. (3-19-07)

26. **Normalized Per Diem Cost**. Refers to direct care costs that have been adjusted based on the nursing facility's case mix index for purposes of making the per diem cost comparable among nursing facilities. Normalized per diem costs are calculated by dividing the nursing facility's direct care per diem costs by its nursing facility-wide case mix index, and multiplying the result by the statewide average case mix index. (3-19-07)

27. **Nurse Practitioner**. A licensed professional nurse (RN) who meets all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-19-07)

28. **Nursing Facility (NF)**. An institution, or distinct part of an institution, which is primarily engaged in providing skilled nursing care and related services for participants. It must be an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. The participant must require medical or nursing care, or rehabilitation services for injuries, disabilities, or illness. (3-19-07)

29. **Nursing Facility Inflation Rate**. See the definition of Inflation Factor in Subsection 011.~~17~~20 of

these rules. ~~(3-19-07)~~(10-1-12)T

30. Ordinary. Ordinary means that the costs incurred are customary for the normal operation of the business. (3-19-07)

31. Out-of-State Care. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (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 257.08 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. For the rate ~~period~~ year of July 1, 2011, through June 30, 2012, rates will be calculated using audited cost reports ended in calendar year 2010 with no allowance for inflation to the rate ~~period~~ year of July 1, 2011, through June 30, 2012. For the rate years beginning July 1, 2012, and annually thereafter, rates will be calculated using audited cost reports for periods ended in the preceding calendar year with no allowance for inflation to the prospective rate period. ~~(3-21-12)~~(10-1-12)T

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, free-standing and urban hospital-based behavioral care unit, or rural hospital-based behavioral care unit) 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)~~(10-1-12)T

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 including behavioral care unit nursing facility providers, or rural hospital-based nursing facilities including behavioral care unit nursing facility providers. ~~(3-19-07)~~(10-1-12)T

06. 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)

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

08. 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~~ this rule~~s~~. ~~(3-19-07)~~(10-1-12)T

258. NURSING FACILITY: COST LIMITS BASED ON COST REPORT.
Each July 1st cost limitations will be established for nursing facilities based on the most recent audited cost report with an end date of June 30th of the previous year or before. Calculated limitations will be effective for a one (1) year period, from July 1 through June 30th of each year, which is the rate year. For the rate ~~period~~ year of July 1, 2011, through June 30, 2012, the direct and indirect cost limits were calculated using the most recent ~~finalized~~ audited cost reports adjusted to the midpoint of the cost reporting year's end in calendar year 2010, to allow for no inflation to the rate year. For rates years beginning July 1, 2012, and annually thereafter, the direct and indirect cost limits will be calculated using the most recent audited cost reports adjusted to the midpoint of each provider's cost reporting year that is used to set the July 1 rate, to allow for no inflation to the rate year. ~~(3-21-12)~~(10-1-12)T

01. Percentage Above Bed-Weighted Median. (10-1-12)T

a. Prior to establishing the first "shadow rates" at July 1, 1999, the estimated Medicaid payments under the previous retrospective system for the year period from July 1, 1999, through June 30, 2000, will be calculated. This amount will then be used to model the estimated payments under the case mix system set forth in Sections 255 through 257 of these rules. The percentages above the bed-weighted median, for direct and indirect costs, will be established at a level that approximates the same amount of Medicaid expenditures as would have been produced by the retrospective system. The percentages will also be established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the retrospective system. (10-1-12)T

b. Once the percentage is established, it will be used to calculate the limit by multiplying the bed-weighted median per diem direct cost times the calculated percentage for that class of provider. There will be a direct and indirect percentage that is applied to freestanding and urban hospital-based nursing facilities, and a higher direct and indirect percentage that is applied to rural hospital-based nursing facilities. (10-1-12)T

c. Beginning with rates effective October 1, 2012, additional direct care cost limit categories will be added for free-standing and urban hospital-based behavioral care units and rural hospital-based behavioral care units. Percentages previously established for other provider class types not considered a behavioral care unit will remain unchanged. Once established, these percentages will remain in effect for future rate setting periods. ~~(3-19-07)~~(10-1-12)T

02. Direct Cost Limits. The direct cost limitation will be calculated by indexing the selected cost data

forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be normalized and arrayed from high to low, with ~~*freestanding and hospital-based*~~ all nursing facilities included in the same array, and the bed-weighted median will be computed. ~~*(3-19-07)*~~(10-1-12)T

03. Indirect Cost Limits. The indirect cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with ~~*freestanding and hospital-based*~~ all nursing facilities included in the same array, and the bed-weighted median will be computed. ~~*(3-19-07)*~~(10-1-12)T

04. Limitation on Increase or Decrease of Cost Limits. Increases in the direct and indirect cost limits will be determined by the limitations calculated in the most recent base year, indexed forward each year from the midpoint of the base year to the midpoint of the rate year by the inflation factor plus one percent (1%) per annum. The calculated direct and indirect cost limits will not be allowed to decrease below the limitations effective in the base year. The maximum rate of growth on the cost limits, and the minimum cost limitation, will be examined by the oversight committee periodically to determine which factors to use in the calculation of the limitations effective in the new base year and forward. (3-29-10)

05. Costs Exempt From Limitations. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in Section 278 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

~~***266. -- 269. (RESERVED)***~~

266. NUSRING FACILITY: BEHAVIORAL CARE UNIT (BCU) AND RATE STRUCTURE.
Effective October 1, 2012, the additional direct care costs associated with BCU residents will remain in direct care costs subject to the direct care cost limitation. Those qualifying BCU nursing facility providers may have a direct care cost limitation higher than non-BCU nursing facility providers. BCU nursing facility providers will not receive an increased indirect care cost limitation. (10-1-12)T

01. Determination. The BCU must have a qualifying program and have been providing care in the BCU to behavior residents as of July 1, 2011. Nursing facility providers that meet the BCU criteria will have BCU direct care costs included in direct care costs subject to the cost limit. The direct care cost limitation may be higher than a non-BCU nursing facility. (10-1-12)T

02. BCU Routine Customary Charge. If the cost to operate a BCU is included in a nursing facility's rate calculation, the nursing facility must report its usual and customary charge for semi-private rooms in both the BCU and general nursing facility. A weighted average routine customary charge is computed to represent the composite of all Medicaid nursing facility residents in the nursing facility based on the type of rooms they occupy, including the BCU. (10-1-12)T

03. Prospective Rate Setting. Beginning October 1, 2012, the direct care cost limit calculation for any special rate revenue offsets in the prior year related to one-to-one (1:1) staffing ratios, BCU, or increased staffing, will be reversed before calculating the cost limit. This revenue offset reversal excludes revenues related to special rate add-ons for ventilator-dependent or tracheostomy services. Rates will be calculated using the cost report ended in the calendar year prior to each July 1 rate setting period with the BCU's direct care costs included in direct care costs subject to the higher BCU cost limit. (10-1-12)T

04. Rates Effective October 1, 2012. For rates effective October 1, 2012, a nursing facility designated as a BCU during each nursing facility provider's cost report ended in calendar year 2011 must be identified.

(10-1-12)T

a. Days approved for a BCU during the 2011 cost report year must be identified. (10-1-12)T

b. To qualify as a BCU, Medicaid BCU days identified in Subsection 266.04.a. of this rule, are divided by total days in the nursing facility and that calculation must equal or exceed a minimum of fifteen percent (15%). (10-1-12)T

05. Annual Rates Beginning July 1, 2013. For annual rates beginning July 1, 2013, once a rate has been set as provided in Subsection 266.03 of this rule, the following process will be used to determine BCU eligibility. A nursing facility must apply for BCU eligibility on an annual basis. Eligibility is determined by: (10-1-12)T

a. BCU days, regardless of payer source, are divided by the total occupied days in the nursing facility and that calculation must equal or exceed a minimum of twenty percent (20%). (10-1-12)T

b. The BCU nursing facility provider must provide a list of all residents they believe were qualified for BCU status for the previous year; (10-1-12)T

i. The Department will select a sample of Idaho Medicaid participants from the submitted list. The nursing facility provider must send the MDS for each selected sample participant, along with related census information, and other requested information to the Department. (10-1-12)T

ii. The Department will review this information to determine that the participants meet the requirements of Subsection 266.06 of this rule and calculate the percentage of BCU days to the total occupied days in the facility to determine whether the facility meets the BCU eligibility requirement in Subsection 266.05.a. of this rule. (10-1-12)T

06. Participant Characteristics. All participants in a BCU must meet the criteria for nursing facility level of care, and have the following characteristics as provided in the participants' MDS assessment: (10-1-12)T

a. Medically based behavior disorder which causes a significantly diminished capacity for judgment, retention of information, or decision making skills, or medically based mental health disorder of diagnosis and has a high level resource use; and (10-1-12)T

b. Must have a history or demonstrate need for additional resources to provide for disruptive behaviors requiring enhanced resource use from nursing facility staff, evidenced by one (1) or more of the following: (10-1-12)T

i. Wandering behaviors; (10-1-12)T

ii. Verbally abusive behaviors; (10-1-12)T

iii. Physically abusive behaviors; (10-1-12)T

iv. Socially inappropriate or disruptive behaviors, such as verbal or vocal symptoms like disruptive sounds, noises, screaming, physical symptoms like self-abusive acts, public sexual behavior or disrobing in public, smearing or throwing food or bodily wastes, hoarding, rummaging through belongings of other residents; (10-1-12)T

v. Behaviors that resist care; or (10-1-12)T

vi. Does not meet unit discharge criteria outlined in Subsection 266.13 of this rule. (10-1-12)T

c. A behavior baseline profile must be established for each participant; (10-1-12)T

d. A behavior intervention program must be in place for each participant, designed to reduce or control the inappropriate behaviors to enhance the participant's quality of life, functional and cognitive status or

safety. (10-1-12)T

07. BCU Annual Renewal. The facility must request continuation in the BCU program annually. The request must include the following: (10-1-12)T

a. A description of the facility's program that includes the required components in Subsections 266.05 and 266.06 of this rule; and (10-1-12)T

b. A profile of the types of behavior of participants served and any restrictions the facility has adopted. (10-1-12)T

08. Administrative and Staffing Requirements. (10-1-12)T

a. Staffing must be at a level necessary for the facility to be able to provide direct supervision of participants as needed. (10-1-12)T

b. Psychiatrist or physician extender must be available to consult as needed for initial and on-going assessments and for 24/7 emergency services. Consultants must make at least quarterly site visits and be available to participate in Behavior Management Team meetings as needed. (10-1-12)T

c. Licensed Master Social Worker (LMSW), Licensed Professional Counselor (LPC), or Licensed Social Worker (LSW) with behavioral experience must be available to consult as needed, make periodic site visits and to participate in the assessment, behavioral intervention planning, behavioral intervention implementation and Behavior Management Team meetings as needed. (10-1-12)T

09. Behavior Management Team Meetings. Weekly behavior management team meetings must be conducted that include but are not limited to psychiatrist, physician, facility social services staff, behavior program director, director of nursing services, dietary manager, recreational services or activity director, and selected primary care staff. Physicians, psychiatrists, social services consultants and other off-site specialists are included as needed, and may participate in person or by telephone. (10-1-12)T

10. Staff Training. Behavioral training classes for staff that are tailored to the needs of the positions involved, and includes appropriate information on: (10-1-12)T

a. Assessment and prevention; (10-1-12)T

b. Medication and side effects; (10-1-12)T

c. Effects of disease process on mood state; (10-1-12)T

d. Safety techniques; (10-1-12)T

e. Deflecting aggression or target behaviors; (10-1-12)T

f. Comprehensive environmental intervention; (10-1-12)T

g. Stress management; and (10-1-12)T

h. Documentation and charting. (10-1-12)T

11. Yearly Training. Yearly training for behavioral interventions and safety techniques is required for staff. (10-1-12)T

12. Care Planning, Behavioral Management, and Programming. Individualized care plans, based on assessments of cognitive and functional abilities, along with behavior analysis to create a strategy for prevention and intervention that are documented for each participant and include the following: (10-1-12)T

a. Thirty (30) day assessments of progress made by each participant, must be completed, documented, and reviewed by the facility's behavioral management team. (10-1-12)T

b. Comprehensive behavior monitoring techniques that track and trend the intensity and daily occurrence of behaviors, successful interventions, and behavior modification techniques used must be documented for each participant. (10-1-12)T

c. Attempts to involve family and responsible parties with the participant through visits, training, outings, or appropriate communications, must be documented. (10-1-12)T

d. Recreational and activity programming must be targeted to specific needs of each individual participant and the behaviors each participant exhibits must be documented. (10-1-12)T

e. Integration for appropriate social interactions must be used when appropriate for each individual participant. (10-1-12)T

f. Community for transition must be used when appropriate for each individual participant. (10-1-12)T

g. Attempts to meet discharge criteria must be documented for each individual participant when progress shows a decline in the need for special care programming. (10-1-12)T

13. Discharge Criteria. The BCU must maintain and document discharge criteria as follows: (10-1-12)T

a. Document improvement in ability to function that would enable transfer to less-restrictive environment. (10-1-12)T

b. Document lack of benefit from specialized programs offered in BCU. (10-1-12)T

c. Document consistent refusals by participant or responsible party to allow interventions that are determined to be helpful, (10-1-12)T

d. Document acute danger to self or others that cannot be managed by staffing in the BCU. (10-1-12)T

e. Document acute physical illness or complications requiring a higher level of medical care than available in the facility. (10-1-12)T

f. A nursing facility provider that is approved for one-hundred percent (100%) behavioral participants will be exempt for the discharge criteria provided in Subsections 266.13.a. through 266.13.e. of this rule. (10-1-12)T

14. Termination of BCU Status. If a provider opts to leave the BCU program, the Department must be notified so the direct care cap can be adjusted to that of a non-BCU provider, beginning with the next rate year. (10-1-12)T

15. Refusal of Admissions. These rules do not preclude a nursing facility from refusing to admit a participant whose needs cannot be met by the nursing facility. (10-1-12)T

267. NURSING FACILITY: NEW BEHAVIORAL CARE UNIT (BCU).

01. Criteria to Qualify as a New BCU. A nursing facility provider must meet the following criteria to qualify as a new BCU nursing facility provider: (10-1-12)T

a. BCU days from the cost report period, regardless of payer source, are divided by the total occupied days in the nursing facility, and that calculation must equal or exceed a minimum of twenty percent (20%). (10-1-12)T

b. A qualifying cost report must demonstrate that the nursing facility provider has a qualifying program in place with residents. (10-1-12)T

02. First Cost Reporting Year. No BCU eligibility, or increased direct care cost limit will be allowed in the first cost reporting year the BCU program is added. (10-1-12)T

03. Qualifying Report in Tandem with BCU Eligibility. Once a qualifying cost report is submitted for the BCU program, and the nursing facility provider qualifies in tandem with the BCU eligibility criteria, the cost report will be used to set a prospective rate effective the following July 1 rate period with the increased direct care cost limit. (10-1-12)T

268. NURSING FACILITY: EXISTING PROVIDER ELECTS TO ADD BEHAVIORAL CARE UNIT (BCU).
An existing nursing facility provider that elects to add a BCU after July 1, 2011, may be deemed eligible after meeting the following requirements: (10-1-12)T

01. Qualifying Cost Report. A qualifying cost report that demonstrates a qualifying program is in place with residents and meets the criteria in Section 282 of these rules. (10-1-12)T

02. Meet Criteria for BCU. The nursing facility provider must meet the criteria for a BCU described in Section 266 of these rules. (10-1-12)T

03. BCU Payments. No BCU payments or increased direct care cost limits will be allowed in the first cost reporting year the program is added. Once a qualifying cost report is submitted, and the provider qualifies in tandem with the BCU criteria, the cost report will be used to set a prospective rate, effective with the following July 1 rate period with the increased direct care cost limit. (10-1-12)T

269. NURSING FACILITY: NEW OWNER OF AN EXISTING NURSING FACILITY WITH A BEHAVIORAL CARE UNIT (BCU).

01. New Owner Elects to Continue BCU. An existing nursing facility that is considered a BCU will continue to be a BCU, if the new owner elects to continue to provide these services. The new owner will receive a rate calculated according to the current change of ownership rules in Section 261 of these rules. The prior owner's cost report will be used until the new owner has a qualifying cost report. They BCU will continue to qualify for the higher direct care cost limit the previous owner was allowed. (10-1-12)T

02. New Owner Does Not Elect to Continue BCU. If the new owner does not elect to operate the BCU, the prior owner's cost report will be used. The direct care cost limit will be adjusted down to that of the non-BCU nursing facility. (10-1-12)T

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 56-265, 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 56-265, Idaho Code, and*~~ in these rules. ~~*(3-19-07)*~~(10-1-12)T

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 thirty (30) days. (3-4-11)

02. Effective Date. Upon approval, a special rate is effective on the date the application was received. (3-4-11)

03. Reporting. Costs equivalent to payments for special rate add-on amounts must be removed from the cost components subject to limits, and be reported separately by the provider. (3-19-07)

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~~ this rule~~s~~ provide clarification of how special rates are paid under the prospective payment system. ~~(3-19-07)~~(10-1-12)T

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.~~d~~c. of ~~these~~ this rule~~s~~. ~~(3-19-07)~~(10-1-12)T

~~*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~~**a.** 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 in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 755, as an add-on amount. ~~(3-4-11)~~(10-1-12)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 residents

who are ventilator-dependent and who receive tracheostomy ~~residents~~ care, ~~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 this rule, adjusted for the appropriate skill level of care staff. The second step is the calculation of an add-on for equipment 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.~~ the special add-on amount to the facility's rate for approved residents receiving this care, is determined by combining the following two (2) components: ~~(3-4-11)~~(10-1-12)T

i. Calculation of a staffing add-on for the cost, if any, for additional direct care staff required in meeting the exceptional needs of these residents. The hourly add-on rate is equal to the current WAHR CNA wage rate plus a benefits allowance based on annual cost report data, then weighted to remove the CNA minimum daily staffing time adjusted for the appropriate skill level of care staff; and (10-1-12)T

ii. Calculation of an add-on for equipment and non-therapy supplies following the provisions in Subsection 270.06.a. of this rule. (10-1-12)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 based on annual cost report data, then weighted to remove the CNA Minimum daily staffing time. (3-4-11)~~

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 costs, an adjustment is made to "offset," or reduce costs by an amount equal to total 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. No related adjustment is made to the facility's CMIs. ~~(3-19-07)~~(10-1-12)T

08. Special Rate for Providers that Change Ownership or Close. When a facility changes ownership or closes, a closing cost report is not required. Special rate payments made in the closing cost reporting period may be reviewed by the Department. (10-1-12)T

(BREAK IN CONTINUITY OF SECTIONS)

622. ICF/ID: PRINCIPLE PROSPECTIVE RATES.
Providers of ICF/ID facilities will be paid a per diem rate which, with certain exceptions, is not subject to an audit settlement. The per diem rate for a fiscal period will be based on audited historical costs adjusted for inflation. The provider ~~will~~ must report these cost items in accordance with other provisions of this chapter or the applicable provisions of PRM consistent with this chapter. Sections 622 through 628 of these rules provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the payment system for ICF/ID providers. Total payment will include the following components: Property reimbursement, capped costs, exempt costs, and excluded costs. Except as otherwise provided in this section, rates calculated for state fiscal year 2012 (July 1, 2011 through June 30, 2012) will be calculated by using finalized cost reports ended in calendar year 2009 with no cost or cost limit adjustments for inflation to the rate period of July 1, 2011, through June 30, 2012. Rates effective July 1, 2012, and every July 1 thereafter, will be calculated by using audited cost reports ended in the calendar year two (2) years prior to each July 1 (July 1, 2012, rates will use cost reports ended in calendar year 2010 and so forth), with no cost or cost limit adjustments for inflation. ~~(3-21-12)~~(10-1-12)T