TITLE 56
PUBLIC ASSISTANCE AND WELFARE
CHAPTER 2
PUBLIC ASSISTANCE LAW

56-265. PROVIDER PAYMENT. (1) Where there is an equivalent, the payment to medicaid providers:

(a) May be up to but shall not exceed one hundred percent (100%) of the current medicare rate for primary care procedure codes as defined by the centers for medicare and medicaid services; and

(b) Shall be ninety percent (90%) of the current medicare rate for all other procedure codes.

(2) Where there is no medicare equivalent, the payment rate to medicaid providers shall be prescribed by rule.

(3) Notwithstanding any other provision of this chapter, if the services are provided by a private, freestanding mental health hospital facility that is an institution for mental disease as defined in 42 U.S.C. 1396d(i), the department shall reimburse for inpatient services at a rate not to exceed ninety-one percent (91%) of the current medicare rate within federally allowed reimbursement under the medicaid program. The reimbursement provided for in this subsection shall be effective until July 1, 2021.

(4) The department shall, through the annual budget process, include a line-item request for adjustments to provider rates. All changes to provider payment rates shall be subject to approval of the legislature by appropriation.

(5) Notwithstanding any other provision of this chapter, the department may enter into agreements with providers to pay for services based on their value in terms of measurable health care quality and positive impacts to participant health.

(a) Any such agreement shall be designed to be cost-neutral or cost-saving compared to other payment methodologies.

(b) The department is authorized to pursue waiver agreements with the federal government as needed to support value-based payment arrangements, up to and including fully capitated provider-based managed care.

(6) Medicaid reimbursement for critical access, out-of-state, and state-owned hospitals shall be as follows:

(a) In-state, critical access hospitals as designated according to 42 U.S.C. 1395i-4(c)(2)(B) shall be reimbursed at one hundred one percent (101%) of cost;

(b) Out-of-state hospitals shall be reimbursed at eighty-seven percent (87%) of cost;

(c) State-owned hospitals shall be reimbursed at one hundred percent (100%) of cost; and

(d) Out-of-state hospital institutions for mental disease as defined in 42 U.S.C. 1396d(i) shall be reimbursed at a per diem equivalent to ninety-five percent (95%) of cost.

(7) The department shall equitably reduce net reimbursements for all hospital services, including in-state institutions for mental disease but excluding all hospitals and institutions described in subsection (6) of this section, by amounts targeted to reduce general fund needs for hospital payments by three million one hundred thousand

dollars ($3,100,000) in state fiscal year 2020 and eight million seven hundred twenty thousand dollars ($8,720,000) in state fiscal year 2021.

(8) The department shall work with all Idaho hospitals, including institutions for mental disease as defined in 42 U.S.C. 1396d(i), to establish value-based payment methods for inpatient and outpatient hospital services to replace existing cost-based reimbursement methods for in-state hospitals, other than those hospitals and institutions described in subsection (6) of this section, effective July 1, 2021. Budgets for hospital payments shall be subject to prospective legislative approval.

(9) The department shall work with Idaho hospitals to establish a quality payment program for inpatient and outpatient adjustment payments described in section 56-1406, Idaho Code. Inpatient and outpatient adjustment payments shall be subject to increase or reduction based on hospital service quality measures established by the department in consultation with Idaho hospitals.

History:

[56-265, added 2011, ch. 164, sec. 16, p. 475; am. 2015, ch. 301, sec. 1, p. 1182; am. 2016, ch. 173, sec. 1, p. 476; am. 2017, ch. 82, sec. 1, p. 226; am. 2020, ch. 35, sec. 2, p. 70.]