TITLE 56
PUBLIC ASSISTANCE AND WELFARE

CHAPTER 1
PAYMENT FOR SKILLED AND INTERMEDIATE SERVICES

56-101. DEFINITIONS. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter and shall have the following meanings:

(1) "Appraisal" means the method of determining the value of the property as determined by an appraisal conducted by a member of the appraisal institute (MAI), or successor organization. The appraisal must specifically identify the values of land, building, equipment, and goodwill.

(2) "Assets" means economic resources of the contractor, recognized and measured in conformity with generally accepted accounting principles.

(3) "Bed-weighted median" is determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median.

(4) "Case mix index" is a numeric score assigned to each facility resident, based on the resident's physical and mental condition, which projects the amount of relative resources needed to provide care to the resident.

(5) "Depreciation" means the systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated useful life of the assets.

(6) "Direct care costs" consists of the following costs directly assigned to the nursing facility or allocated to the nursing facility through medicare cost finding principles:

(a) Direct nursing salaries which include the salaries of registered nurses, licensed professional nurses, certificated nurse's aides, and unit clerks; and

(b) Routine nursing supplies; and

(c) Nursing administration; and

(d) Direct portion of medicaid related ancillary services; and

(e) Social services; and

(f) Raw food; and

(g) Employee benefits associated with the direct salaries.

(7) "Director" means the director of the department of health and welfare or the director's designee.

(8) "Equity" means 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.

(9) "Facility" means an entity which contracts with the director to provide services to recipients in a structure owned, controlled, or otherwise operated by such entity, and which entity is responsible for operational decisions. In conjunction with the use of the term "facility":

(a) "Freestanding intermediate care" means an intermediate care facility, as defined in and licensed under chapter 13, title 39, Idaho Code, which is not owned, managed, or operated by, nor is otherwise a part of a hospital, as defined in section 39-1301(a), Idaho Code; and

(b) "Freestanding skilled care" means a nursing facility, as defined in and licensed under chapter 13, title 39, Idaho Code, which is not owned, managed, or operated by, nor is otherwise a part of a hospital, as defined in section 39-1301(a), Idaho Code; and

(c) "Freestanding special care" means a facility that provides either intermediate care, or skilled care, or intermediate care for people with intellectual disabilities, or any combination of either, which is not owned, managed, or operated by, nor is otherwise a part of a hospital, as defined in section 39-1301(a), Idaho Code; and

(d) "Hospital-based" means a nursing or intermediate care facility, as defined in and licensed under chapter 13, title 39, Idaho Code, which is owned, managed, or operated by, or is otherwise a part of a hospital, as defined in section 39-1301(a), Idaho Code.

(10) "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.

(11) "Goodwill" means the amount paid by the purchaser that exceeds the net tangible assets received. 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 nonallowable, nonreimbursable expense.

(12) "Historical cost" means the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architect's fees, and engineering studies.

(13) "Indirect care costs" consists of the following costs either directly coded to the nursing facility or allocated to the nursing facility through the medicare step-down process:

(a) Administrative and general care cost; and

(b) Activities; and

(c) Central services and supplies; and

(d) Laundry and linen; and

(e) Dietary ("non-raw food" costs); and

(f) Plant operation and maintenance (excluding utilities); and

(g) Medical records; and

(h) Employee benefits associated with the indirect salaries; and

(i) Housekeeping; and

(j) Other costs not included in direct care costs or costs exempt from cost limits.

(14) "Interest rate limitation" means that the interest rate allowed for working capital loans and for loans for major movable equipment for intermediate care facilities for people with intellectual disabilities shall be 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. All interest expense greater than the amount derived by using the limitation above shall be nonreimbursable; provided, however, that this interest rate limitation shall not be imposed against loans or leases which

were made prior to July 1, 1984. Said loans or leases shall be subject to the tests of reasonableness, relationship to patient care and necessity.

(15) "Intermediate care facility for people with intellectual disabilities" means an habilitative facility designed and operated to meet the educational, training, habilitative and intermittent medical needs of the developmentally disabled.

(16) "Major movable equipment" means such items as accounting machines, beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are:

(a) A relatively fixed location in the building;

(b) Capable of being moved, as distinguished from building equipment;

(c) A unit cost sufficient to justify ledger control;

(d) Sufficient size and identity to make control feasible by means of identification tags; and

(e) A minimum life of approximately three (3) years.

(17) "Medicaid" means the 1965 amendments to the social security act (P.L. 89-97), as amended.

(18) "Minor movable equipment" includes such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, buckets, etc. The general characteristics of this equipment are:

(a) In general, no fixed location and subject to use by various departments of the provider's facility;

(b) Comparatively small in size and unit cost;

(c) Subject to inventory control;

(d) Fairly large quantity in use; and

(e) Generally, a useful life of approximately three (3) years or less.

(19) "Net book value" means the historical cost of an asset, less accumulated depreciation.

(20) "Normalized per diem costs" refers to direct care costs that have been adjusted based on the facility's case mix index for purposes of making the per diem costs comparable among facilities. Normalized per diem costs are calculated by dividing the facility's direct care per diem costs by its facility-wide case mix index, and multiplying the result by the statewide average case mix index.

(21) "Nursing facility inflation rate" means the most specific skilled nursing facility inflation rate applicable to Idaho established by data resources, inc., or its successor. If a state or regional index has not been implemented, the national index shall be used.

(22) "Patient-day" means a calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3:00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care shall be deemed to exist.

(23) "Property costs" means the total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal.

(24) "Raw food" means food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions.

(25) "Reasonable property insurance" means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance

per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year shall not be considered reasonable.

(26) "Recipient" means an individual determined eligible by the director for the services provided in the state plan for medicaid.

(27) "Rural hospital-based nursing facilities" are those hospital-based nursing facilities not located within a metropolitan statistical area (MSA) as defined by the United States bureau of the census.

(28) "Urban hospital-based nursing facilities" are those hospital-based nursing facilities located within a metropolitan statistical area (MSA) as defined by the United States bureau of the census.

(29) "Utilities" means all expenses for heat, electricity, water and sewer.

[56-101, added 1981, ch. 159, sec. 1, p. 271; am. 1984, ch. 118, sec. 1, p. 264; am. 1985, ch. 128, sec. 1, p. 312; am. 1986, ch. 87, sec. 1, p. 251; am. 1988, ch. 155, sec. 1, p. 279; am. 1999, ch. 82, sec. 1, p. 265; am. 2000, ch. 274, sec. 146, p. 878.; am. 2010, ch. 235, sec. 41, p. 576.]

56-116. NURSING FACILITY PAYMENT METHODOLOGY. The department shall work with Idaho nursing facility providers to establish a new prospective payment method for nursing facilities to replace existing reimbursement methods. Payments to nursing facilities under this method shall take into account patient needs, facility quality of care, reasonable cost principles, and state budget limitations. Budgets for nursing facility payments shall be subject to prospective legislative approval. The new payment methodology shall be implemented effective July 1, 2021.

[56-116, added 2020, ch. 35, sec. 1, p. 70.]

PART A
GENERAL PROVISIONS

56-104. RECAPTURE OF DEPRECIATION. (a) Where depreciable assets that were reimbursed based on cost and were used in the medicaid program subsequent to January 1, 1982, and for which depreciation has been reimbursed by the director, are sold for an amount in excess of their net book value, depreciation so reimbursed shall be recaptured from the buyer of the facility in an amount equal to reimbursed depreciation or gain on the sale, whichever is less. Depreciation shall be recaptured in full if a sale of a depreciated facility takes place within the first five (5) years of seller's ownership after January 1, 1982.

(b) Depreciation shall be recaptured by the director from the buyer of the facility over a period of time not to exceed five (5) years from the date of sale, with not less than one-fifth (1/5) of the total amount being recaptured for each year after such date.

(c) Leases of facilities entered into on or after the effective date of this subsection shall be reimbursed in the same manner as an owned asset, with recapture of depreciation being effected against the buyer of the facility in the case where the facility's assets are sold by the lessor of the facility. Leases in existence prior to the effective date of this subsection shall be reimbursed at the rate established prior to such date for each such

lease. Renegotiated leases shall be reimbursed at established rates, plus a reasonable annual increase.

[56-104, added 1981, ch. 159, sec. 1, p. 273; am. 1985, ch. 128, sec. 2, p. 315; am. 1986, ch. 87, sec. 2, p. 253.]

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

(1) Except as determined pursuant to this section:

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

where:

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

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

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

(i) If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the director shall set the effective age at thirty (30) years. Adequate documentation shall include, but not be limited to, such documents as copies of building permits, tax

assessors' records, receipts, invoices, building contracts, and original notes of indebtedness. The director shall compute an appropriate age for facilities when documentation is provided to reflect expenditures for building expansion or remodeling prior to the effective date of this section. The computation shall decrease the age of a facility by an amount consistent with the expenditure and the square footage impacted and shall be calculated as follows:

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

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

3. The age of the building at the time of construction shall be multiplied by the quotient of total actual renovation or remodeling costs divided by replacement cost. If this number is equal to or greater than 2.0, the age of the building in years will be reduced by this number, rounded to the nearest whole number. In no case will the age be less than zero (0).

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

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

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

(2) A "grandfathered rate" for existing facilities will be determined by dividing the audited allowable annual property costs, exclusive of taxes and insurance, for assets on hand as of January 1, 1985, by the total patient

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

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

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

(b) In the event of a forced sale of a facility where the seller has been receiving a grandfathered rate, the buyer will receive a rate based upon his incurred property costs, exclusive of taxes and insurance, for the

twelve (12) months following the sale, divided by the facility's total patient days for that period, or the property rental rate, whichever is higher, but not exceeding the rate that would be due the seller.

[56-108, added 1985, ch. 128, sec. 3, p. 316; am. 1986, ch. 87, sec. 3, p. 253; am. 1989, ch. 417, sec. 1, p. 1018; am. 1990, ch. 67, sec. 1, p. 146; am. 1991, ch. 160, sec. 1, p. 384; am. 1993, ch. 351, sec. 1, p. 1307; am. 1999, ch. 82, sec. 3, p. 271; am. 2010, ch. 235, sec. 42, p. 579; am. 2011, ch. 164, sec. 3, p. 463.]

PART B
FREE-STANDING SKILLED CARE AND INTERMEDIATE CARE FACILITIES

56-114. FREESTANDING SPECIAL CARE FACILITIES. For a freestanding special care facility which seeks to contract for the first time to provide medicaid services to recipients, the director shall determine payment for such facility as specified in rule.

[56-114, added 1988, ch. 155, sec. 2, p. 282; am. 1999, ch. 82, sec. 5, p. 276.]

56-117. PAYMENT OF SPECIAL RATES. The director shall have authority to pay facilities at special rates for care given to patients who have long-term care needs not adequately reflected in the rates calculated pursuant to the principles set forth in section 56-265, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of section 56-265, Idaho Code, will be excluded from the computation of payments or rates under other provisions of this chapter. Until the facility applies for a special rate, patients with such needs will be included in the computation of the facility's rates following the principles described in section 265 [56-265], Idaho Code.

[56-117, added 1989, ch. 362, sec. 2, p. 908; am. 1999, ch. 82, sec. 6, p. 276; am. 2011, ch. 164, sec. 5, p. 466.]

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

(2) In addition to any policy or federal statutory requirements, such methodology shall incorporate, at a minimum, the actual cost of providing quality services, including personnel and total operating expenses, directly related to providing such services which shall be provided by the private business entities.

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

[56-118, added 2005, ch. 86, sec. 1, p. 304; am. 2011, ch. 164, sec. 6, p. 467.]

PART C
HOSPITAL-BASED FACILITIES

56-120. PROPERTY REIMBURSEMENT FOR HOSPITAL-BASED SKILLED NURSING FACILITIES. In addition to the basic payment per patient-day of care, each hospital-based nursing facility shall be paid on a prospective basis its actual property and utility costs per patient-day, to be determined by dividing its total projected property and utility costs, as calculated from the cost report selected for rate setting, by the total number of patient-days from the same cost reporting period.

[56-120, added 1981, ch. 159, sec. 1, p. 277; am. 1984, ch. 118, sec. 6, p. 269; am. 1985, ch. 128, sec. 9, p. 321; am. 1999, ch. 82, sec. 7, p. 277; am. 2000, ch. 274, sec. 147, p. 881.]

PART D
MISCELLANEOUS

56-131. MULTIPLE-USE PLANS. The director shall promulgate such rules, as the director deems advisable to enable and encourage facilities to adopt plans for offering additional services or programs within their institutions which will promote appropriate levels of care for recipients residing in their service areas and, as a result, achieve cost savings for the medicaid program. In developing such rules, the director shall consult with representatives of freestanding skilled care, freestanding intermediate care, freestanding special care, and hospital-based facilities.

[56-131, added 1981, ch. 159, sec. 1, p. 279; am. 1988, ch. 155, sec. 3, p. 282; am. 1999, ch. 82, sec. 8, p. 278.]

56-132. DISPUTES. (a) If any facility wishes to contest the way in which a rule or contract provision relating to the prospective, cost-related reimbursement system was applied to such facility by the director, it shall first pursue the administrative review process set forth in section 56-133, Idaho Code.

(b) The administrative review process in section 56-133, Idaho Code, need not be exhausted if a facility wishes to challenge the legal validity of a statute, rule, or contract provision.

[56-132, added 1981, ch. 159, sec. 1, p. 280.]

56-133. ADMINISTRATIVE REVIEW PROCESS. (a) Within thirty (30) days after a facility is notified of an action or determination it wishes to challenge, such facility shall request in writing that the director review such determination. The request shall be signed by the licensed administrator of the facility, shall identify the challenged determination and the date thereof, and shall state as specifically as practicable the grounds for its contention that the determination was erroneous. Copies of any documentation on which such facility intends to rely to support its position shall be included with the request.

(b) After receiving a request meeting the above criteria, the director will contact the facility to schedule a conference for the earliest mutually

convenient time. The conference shall be scheduled for no later than thirty (30) days after a properly-completed request is received, unless both parties agree in writing to a specified later date.

(c) The facility and the director shall attend the conference. In addition, representatives selected by the facility may attend and participate. The facility shall bring to the conference, or provide to the director in advance of the conference, any documentation on which the facility intends to rely to support its contentions. The parties shall clarify and attempt to resolve the issues at the conference. If additional documentation is needed to resolve the issues, a second session of the conference shall be scheduled for not later than thirty (30) days after the initial session, unless both parties agree in writing to a specific later date.

(d) A written decision by the director will be furnished to the facility within thirty (30) days after the conclusion of the conference.

(e) If the facility desires review of an adverse decision of the director, it shall, within twenty-eight (28) days following receipt of such decision, request a hearing in writing on the contested matter, in accordance with the provisions of chapter 52, title 67, Idaho Code.

[56-133, added 1981, ch. 159, sec. 1, p. 280; am. 1993, ch. 216, sec. 94, p. 664.]

56-134. DENIAL, SUSPENSION, REVOCATION OF LICENSE OR PROVISIONAL LICENSE -- PENALTY. The director is authorized to deny, suspend, or revoke a license or provisional license or, in lieu thereof or in addition thereto, assess monetary penalties of a civil nature not to exceed one thousand dollars ($1,000) per violation in any case in which it finds that the facility, or any partner, officer, director, owner of five per cent (5%) or more of the assets of the facility, or managing employee:

(1) Failed or refused to comply with the requirements of this chapter, or the rules and regulations established hereunder; or

(2) Has knowingly or with reason to know made a false statement of a material fact in any record required by this chapter; or

(3) Refused to allow representatives or agents of the director to inspect all books, records, and files required to be maintained by the provisions of this chapter, or to inspect any portion of the facility's premises; or

(4) Wilfully prevented, interferred [interfered] with, or attempted to impede in any way the work of any duly authorized representative of the director and the lawful enforcement of any provision of this chapter; or

(5) Wilfully prevented or interferred [interfered] with any representative of the director in the preservation of evidence of any violation of any of the provisions of this chapter, or the rules and regulations promulgated hereunder.

[56-134, added 1981, ch. 159, sec. 1, p. 280.]

56-134A. REMEDIES FOR DEFICIENT CARE. If the director finds that a facility is deficient in, or no longer meets, any of the requirements of participation set forth in 42 U.S.C. 1396r(b), (c) and (d), which are hereby incorporated by reference, the director has the authority, as provided in title XIX of the social security act, to:

(1) terminate the facility's participation in the medicaid program;

(2) deny payment;

(3) assess and collect a civil money penalty with interest;
(4) appoint temporary management of the facility;
(5) close the facility and/or transfer residents to another certified facility;
(6) direct a plan of correction;
(7) ban admission of persons with certain diagnoses or requiring specialized care;
(8) ban all admissions to the facility;
(9) assign monitors to the facility; or
(10) reduce the licensed bed capacity.

[56-134A, added 1990, ch. 303, sec. 1, p. 833.]

56-135. ADOPTION OF RULES. The director shall adopt, promulgate, amend, and rescind such administrative rules as are necessary to carry out the policies and purposes of this chapter, as provided in chapter 52, title 67, Idaho Code.

[56-135, added 1981, ch. 159, sec. 1, p. 281.]