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**State/Territory Name: Idaho**

**State Plan Amendment (SPA) #: 21-0011**

This file contains the following documents in the order listed:


1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

**Financial Management Group**

November 22, 2021

Elizabeth Kriete, Acting Administrator
Idaho Department of Health and Welfare
Division of Medicaid
P.O. Box 83720
Boise, ID 83720-0009

Re: Idaho 21-0011

Dear Ms. Kriete:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 21-0011. Effective for services on or July 1, 2021, this amendment revises the reimbursement methodology for Acute Care Hospitals. Specifically, this amendment transitions the current cost based reimbursement methodology for these hospitals to a Prospective Payment System (PPS) All Patient Refined (APR) Diagnosis Related Group (DRG) methodology.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 21-0011 is approved effective July 1, 2021. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at Christine.storey@cms.hhs.gov or 303-844-7044.

Sincerely,

[redacted]

Rory Howe
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938 0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: **ID-21-0011**

2. STATE **IDAHO**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
**07-01-2021**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
**1905(t) of the Social Security Act**
See Block 23. Remarks

7. FEDERAL BUDGET IMPACT:
**FFY2021 $0**
**FFY2022 $0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
**Attachment 4.19-A pages 1-8, 12, 13**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
**Attachment 4.19-A pages 1-8, 12, 13**

10. SUBJECT OF AMENDMENT:
**Amendment to the State Plan to update the inpatient reimbursement methodology for acute care hospitals.**

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE O [redacted]

13. TYPED NAME
**Elizabeth Kriete**

14. TITLE:
**Acting Administrator**

15. DATE SUBMITTED:
**08/25/2021**

16. RETURN TO:

Elizabeth Kriete, Acting Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0009

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:
August 25, 2021

18. DATE APPROVED:
November 22, 2021

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2021

[redacted] For

21. TYPED NAME:
Rory Howe

22. TITLE:
Director, Financial Management Group

23. REMARKS:

State authorized CMS to reflect pen and ink change to Box #6. 1905(t) is replaced with SSA citation 1905(a)(1).

449. MAXIMUM PAYMENT TO HOSPITALS. For hospitals that are subject to cost settlement (critical access and state-owned, as described below under Reasonable Costs), pursuant to the provisions of Title XIX of the Social Security Act, in reimbursing hospitals, the Department will pay in behalf of MA recipients the lesser of Customary Charges or the Reasonable Cost of inpatient services in accordance with procedures detailed in Sections 450 through 499. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment which would be determined as a Reasonable Cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement.

01. Indian Health Hospitals. Payment for Indian Health Services (IHS)/tribal 638 inpatient hospital services is made at the most current inpatient hospital per diem rate published by IHS in the Federal Register.

450. THIS SECTION INTENTIONALLY LEFT BLANK.

451. DEFINITIONS. In determining hospital reimbursement on the basis either of Customary Charges or of the Reasonable Cost of inpatient services under Medicaid guidelines, whichever is less, the following will apply:

• Allowable Costs. For those providers subject to cost settlement, the Current Year's Title XIX apportionment of a hospital's allowable costs determined at final or interim settlement consist of those costs permitted by the principles of reimbursement contained in the Provider Reimbursement Manual Parts I and II (PRM) and do not include costs already

having payment limited by Medicaid rate file or any other Medicaid charge limitation.

• Apportioned Costs. For those providers subject to cost settlement apportioned Costs consist of the share of a hospital's total allowable costs attributed to Medicaid program recipients and other patients so that the share borne by the program is based upon actual services received by program recipients, as set forth in the applicable Title XVIII principles of cost reimbursement as specified in Provider Reimbursement Manual, PRM—15, and in compliance with Medicaid reimbursement rules.

• Capital Costs. For those providers subject to cost settlement, for the purposes of hospital reimbursement, Capital Costs are those allowable costs considered in the final settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes.

• Case-Mix Index. The Case-Mix Index for a hospital is the average weight of values assigned to a range of diagnostic related groups and applied to Medicaid discharges. The index will measure the relative resources required to treat Medicaid inpatients. The Case-Mix Index of the Current Year will be divided by the index of the Principal Year to assess the percent change between the years.

• Charity Care. Charity Care is care provided to individuals who have no source of payment third-party or personal resources.

• Children's Hospital. A Children's Hospital is a Medicare certified hospital as set forth in 42 CFR Section 412.23 (d)

• Critical Access Hospitals (CAH). A rural hospital with twenty-five (25) or less beds as set forth in 42 CFR Section 485.602.

• Cost Report. A Cost Report is the complete Medicare cost reporting form HCFA 2552, or its successor, as completed in full and accepted by the Intermediary for Medicare cost settlement and audit.

• Current Year. Any hospital cost reporting period for which Reasonable Cost is being determined will be termed the Current Year.

• Disproportionate Share Hospital (DSH) Allotment Amount. The Disproportionate Share Hospital (DSH) Allotment Amount is determined by CMS which is eligible for federal matching funds in the federal fiscal period for disproportionate share payments.

• Disproportionate Share Threshold. The Disproportionate Share Threshold shall be: a. the arithmetic mean plus one (1) standard deviation of the Medicaid Inpatient Utilization Rates of all Idaho hospitals; or, b. a Low Income Utilization Rate exceeding twenty-five percent (25%).

• DSH Survey. The DSH Survey is an annual data request from the Department to the hospitals to obtain the information necessary to compute DSH pursuant to Subsection 454.02.

• Excluded Units. Excluded Units are distinct units in hospitals which are certified by Medicare according to 42 CFR Sections 412.25, 412.27 and 412.29 for exclusion from the Medicare prospective payment system.

• Hospital Inflation Index. The table named Global Insight Hospital Market Basket in the reference manual published by Global Insight titled "Health-Care Cost Review," or its successor, is used to calculate the quarterly moving average inflation rate.

• Medicaid Inpatient Utilization Rate (MUR). The MUR for each hospital will be computed using the Department's record of paid inpatient days for the fiscal year divided by the total inpatient days for the same fiscal year as reported in the DSH Survey. In this paragraph, the term "inpatient days" includes newborn days, days in specialized wards, and days provided to an inappropriate level of care. Days provided at an inappropriate level of care includes administrative necessary days, and Medicaid inpatient days from other states. In this paragraph, "Medicaid inpatient days" includes paid days not counted in prior DSH Threshold computations.

• Low Income Utilization Rate. The Low Income Utilization Rate is the sum of the following fractions, expressed as a percentage: a. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues and case subsidies of the hospital for inpatient services in the same cost reporting period; plus b. the total amount of the hospital's charges for inpatient hospital services attributable to charity care in the same cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts and reduction in charges given to Medicare, Medicaid, other third-party payers, or cash for inpatient services received directly from state and local governments county assistance programs.

• Medicaid Inpatient Day. For purposes of DSH payments, an inpatient day is defined as a Medicaid payment day in a hospital for which there is also no Medicare inpatient day counted.

• Obstetricians. For purposes of an adjustment for hospitals serving a disproportionate share of low income patients, and in the case of a hospital located in a rural area, as defined by the Federal Executive Office of Management and Budget, the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

Operating Costs. For the purposes of hospital reimbursement, Operating Costs are the allowable costs included in the cost centers established in the finalized Medicare Cost Report to accumulate costs applicable to providing routine and ancillary services to patients for the purposes of cost assignment and allocation in the step-down process.

Other Allowable Costs. Other Allowable Costs are those Reasonable Costs recognized under the Medicaid Reasonable Cost principles for services not subject to Medicaid limitations of coverage or reimbursement limits. Costs which are not reimbursed as Operating Costs, but recognized by Medicare principles as Allowable Costs will be included in the total Reasonable Costs. Other Allowable Costs include, but are not necessarily limited to, physician's component which was combined-billed, Capital Costs, ambulance costs, excess costs carry-forwards and medical education costs.

• Reasonable Costs. Reasonable Costs includes all necessary and ordinary costs incurred in rendering the services related to patient care which a prudent and cost-conscious hospital would pay for a given item or service, which do not exceed the Title XIX cost limit. The following provider types are cost settled and reimbursed as described below effective 7/1/21.

a. No more than one hundred one percent (101%) of cost will be reimbursed to in-state Critical Access Hospitals (CAHs) as defined in 42 U.S.C. 1395i-4(c)(2)(B).

b. No more than one hundred percent (100%) of cost will be reimbursed to state-owned hospitals.

c. No more than one hundred percent (100%) of cost will be reimbursed to Idaho hospitals for medical education costs only; no more than eighty-seven (87%) of cost will be reimbursed to applicable out of state hospitals for medical education costs only.

• TEFRA. TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248.

• Uninsured Patient Costs. For purposes of determining additional costs beyond uncompensated Medicaid costs that may be reimbursed as a DSH payment without exceeding the State Allotment Amount, only inpatient costs of uninsured patients will be considered.

• Upper Payment Limit. The Upper Payment Limit for hospital services shall be as defined in Chapter 42 of the Code of Federal Regulations.

452. TITLE XIX INPATIENT SERVICES FROM A PRIOR PERIOD COST SETTLEMENT IN THE CURRENT PERIOD:

a. Title XIX claims for dates of Service Prior to a Current Year. Claims from prior service periods that were not captured in a prior cost settlement will be cost settled in the current year using cost-to-charge ratios and routine cost per diems from the Medicare cost report currently being settled.

453. REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES: INPATIENT PROSPECTIVE PAYMENT SYSTEM

Notwithstanding any other provisions of this State Plan, for discharges on or after July 1, 2021, reimbursement for acute inpatient hospital services that are provided to Idaho Medicaid beneficiaries is described and governed by this section of attachment 4.19-A.

01. Definitions

a. "3M™ All Patient Refined Diagnosis Related Group" or "3M™ APR DRG" is a type of classification system used to assign inpatient stays to a DRG. Under the 3M APR DRG system, a specific code is assigned to each claim by a grouping algorithm that utilizes the diagnoses code(s), procedure code(s), patient birthdate, patient age, patient gender, admit date, discharge date, and discharge status on that claim.

b. "Base DRG" is the first three numeric values of a DRG in the 3M APR DRG classification system.

c. "Base Rate" is the base payment amount per discharge before the relative weight of the DRG or policy adjustors are applied.

d. "Base Payment" is the DRG base payment for inpatient hospital services, calculated by multiplying the Base Rate times the Relative Weight.

e. "Designated Border Hospitals" are hospitals not located in Idaho that have been determined by the Idaho Medicaid program to provide important services to Idaho Medicaid members. To be classified as a Designated Border Hospital, a hospital must be located in Washington, Oregon, Nevada, Wyoming, Utah, or Montana, and meet claims volume or cost thresholds determined by the Idaho Department of Health and Welfare. Designated Border Hospital status is determined on a periodic basis by the agency.

f. "DRG" or "Diagnosis Related Groups" is patient classification system that standardizes prospective payments to hospitals by grouping services that consume similar hospital resources.

g. "DRG Grouper" is the software application used to assign an inpatient hospital claim to a DRG.

h. "Exempt Hospitals and Services" are those hospitals and services not subject to the DRG payment methodology.

i. "Outlier Factor" is the DRG Dollar Threshold divided by Base Rate multiplied by the Relative Weight.

j. "Default Percentage" is the percentage the outlier calculation will pay.

k. "DRG Dollar Threshold" is set dollar amount for all 3M APR DRGs used in the calculation of the Outlier Factor.

l. "Out-of-State Hospitals" are hospitals not located in Idaho that do not meet the definition of Designated Border Hospitals in 453.01.e.

m. "Outlier Payment" is a payment amount in addition to the DRG Payment.

n. "Policy Adjustor" is a factor applied to the calculation of the DRG payment in which the Base Rate is multiplied by the Relative Weight and further multiplied by the Policy Adjustor. Policy Adjustors may be established for specific types of inpatient hospital services or for specific hospitals.

o. "Relative Weight" is a numeric value representing the average resource consumption for the DRG.

p. "Severity of Illness" or "SOI" is the fourth numeric value of a DRG in the 3M APR DRG classification system.

02. Applicability

a. Except as specified below in Paragraph B.2, for admissions dated July 1, 2021, and after, the Idaho Department of Health and Welfare will reimburse hospitals through a prospective payment methodology based upon DRGs.

b. The following Exempt Hospitals and Services are not reimbursed based on the DRG payment methodology:

i. Institutions of Mental Disease (IMDs), including out-of-state IMDs

ii. In-state Critical Access Hospitals

iii. Inpatient hospice

iv. Swing-bed stays

v. Idaho state-owned hospitals

03. DRG Reimbursement

For discharges dated July 1, 2021, and after, reimbursement to hospitals for inpatient hospital services beneficiaries is based on the DRG payment method. Under the DRG payment method, the DRG Base Payment is determined by multiplying a DRG Base Rate by a DRG Relative Weight. The DRG Base Payment may be adjusted through the application of policy adjustors, as applicable. Provided all pre-payment review requirements have been approved by the Idaho Department of Welfare, DRG reimbursement is for each admit through discharge claim, unless otherwise specified in this segment of Attachment 4.19-A.

a. DRG Base Rate – The Base Rate is the amount that is applied to the Relative Weight to determine the Base Payment. The Base Rate for in-state hospitals is a statewide Base Rate. Separate Base Rates may be established for Designated Border and other out-of-state hospitals. Current DRG Base Rates can be found in the Hospital, Idaho Medicaid Provider Handbook.

b. DRG Relative Weight - The DRG Relative Weight is determined from the Base DRG and Severity of Illness values assigned to the claim by the 3M APR DRG Grouper. The DRG Relative Weight values for the 3M APR DRG grouper are obtained from 3M™ Health Information Systems and comprise four severities of illness and risk of mortality sub classes: minor (1), moderate (2), major (3), and extreme (4). The DRG Relative Weight values may be scaled to represent Idaho Medicaid claims experience. Each discharge claim is assigned only one 3M APR DRG code. Current DRG Relative Weights can be found in the Hospital section of the Idaho Medicaid Provider Handbook.

c. Policy Adjustors – Policy adjustors are multipliers that may increase or decrease DRG payment amounts based on DRG assignment, patient age, and/or hospital type. The Idaho Department of Welfare will determine the criteria and specific values for each policy adjustor. Current Policy Adjustors can be found in the Hospital, Idaho Medicaid Provider Handbook.

d. Outlier payment policy – Outlier payments are determined by assigning a dollar threshold and default percentage that would be consistent with each claim. A claim is eligible for an outlier payment if it is not adjusted for the transfer policy and the charges must exceed the adjusted base rate multiplied by the adjusted weight multiplied by the outlier factor. Current dollar thresholds and default percentages can be found in the Hospital, Idaho Medicaid Provider Handbook.

e. Transfer payment policy – Inpatient hospital services are subject to a transfer payment policy when a hospital transfers a patient to another hospital during the same episode of care. The transfer payment policy applies to the hospital making the transfer (transferring hospital). The hospital receiving the patient is not subject to the transfer payment policy. Payment to the transferring hospital is prorated based on the actual length of stay. Claims grouping to 3M APR DRGs 580 or 581 (neonate transfers) are excluded from the transfer payment policy. Claims will be identified as transfer claims based on the discharge status code. Current Discharge Status Codes subject to the Transfer Payment Policy can be found in the Hospital, Idaho Medicaid Provider Handbook.

f. Charge limit – Payment for inpatient hospital services subject to the DRG payment methodology shall not exceed the hospital's billed charges.

g. Excluded hospitals – The following hospitals will be excluded from the DRG payment methodology: institutions of Mental Disease (IMDs), in-state critical access hospitals, inpatient hospice, and Idaho state-owned.

h. Separately payable services, supplies, and devices – No supplies, services, or devices (such as organ acquisition costs, blood factors, or long-acting reversible contraceptives) will be carved out of the DRG payment method.

i. Out-of-State hospital reimbursement – Reimbursement for inpatient services at out-of-state hospitals (except IMDs) will be reimbursed using the DRG methodology applicable to in-state hospitals. Separate base rates may be established for Designated Border Hospitals and all other out-of-state hospitals.

j. Readmissions – Readmissions will be treated as initial inpatient readmissions and receive separate DRG payment.

k. Partial eligibility – In cases where a patient gains or loses Medicaid eligibility during an inpatient stay, a split bill must be submitted. A DRG assignment and payment will be determined based on the claim for Medicaid covered days.

l. Reviews and appeals - In general, providers may submit written inquiries or submit appeals following 16.03.09.205, concerning the rate determination process. Only the following will be considered under the procedures herein described: evidence that the cost report figures used to determine the base rate contained an error on the part of the Idaho Department of Health and Welfare or its agents; or evidence that the Idaho Department of Health and Welfare is not complying with its stated policies in determining the base rates, trend factor, or utilization constraints. Information concerning the base rate will be provided to each hospital prior to the effective date.

m. Payment in full - Participating providers must accept the amount paid in accordance with the Idaho Title XIX Inpatient Hospital Reimbursement Plan as payment in full for covered services.

n. DRG System Updates – The Idaho Department of Health and Welfare will review base rates, policy adjustors, and other payment parameters as needed. Any changes may be implemented at a frequency determined by the state but no more often than annually.

04. Payment formulas will be outlined in the Idaho Medicaid Provider Agreement.

Payment formulas, policy adjustors, DRG relative weights, and DRG base rates are also listed in the DRG calculator found on the Department of Health Welfare website under Providers at https://healthandwelfare.idaho.gov.

454. Adjustment for Disproportionate Share Hospitals (DSH). All Idaho hospitals serving a disproportionate share of low income patients must qualify either as a Mandatory DSH or as a Deemed DSH to receive a DSH payment.

01. DSH Survey Requirements. On or before January 31, of each calendar year, the Department will send each hospital a DSH survey. Each hospital shall return the DSH Survey on or before May 31, of the same calendar year. A hospital shall not be entitled to a DSH payment if the hospital fails to return the DSH survey by the May 31, deadline without good cause as determined by the Department. From the DSH Survey and Department data, payments distributing the state's annual DSH allotment amount will be made by September 30, of the same calendar year.

02. Mandatory Eligibility for DSH Status shall be provided for all hospitals which:

a. Meets or exceeds the Disproportionate Share Threshold as defined in Subsection 451.12.

b. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services.

i. Subsection 454.02.b does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or

ii. Did not offer non-emergency inpatient obstetric services as of December 21, 1987.

06. DSH Payment Distribution.

a. DSH payments will be calculated for distribution to Mandatory DSH hospitals, defined in section 454.02, first, then to Deemed DSH hospitals, defined in section 454.03. When there is a balance of federally allotted DSH money after Mandatory DSH and Deemed DSH payments have calculated, the balance of DSH money will be calculated for distribution to all eligible hospitals until the balance of DSH money is zero.

b. DSH payments made to private hospitals are governed by Idaho Code 56-1401 passed in the 2009 Legislative session.

456. OUT-OF-STATE HOSPITALS.

01. Out-of-state hospitals will be reimbursed under 3M™ All Patient Refined DRG (3M APR DRG) as described in section 453.

2. Payment for Hospitals without Cost Settlement. Those out-of-state hospitals not cost settling with the state will have annually adjusted rates of payment no greater than seventy-five percent (75%) for inpatient covered charges. This rate represents an average inpatient reimbursement rate paid to Idaho hospitals.

3. Payment For Out Of State Hospitals That Perform Specialized Services Or Procedures Unavailable At Instate Hospitals. In cases where the Department determines that a Medicaid client is having access difficulty because there are no instate hospitals available that can perform the particular service or procedure needed, the Department may negotiate a payment rate with an out of state hospital that can perform the service or procedure needed, rather than cost settle with them. The Department will set a payment rate that will reimburse the hospital on a reasonable cost basis under Medicare cost reimbursement principles. The established payment ceiling will be 100% of costs, and the payment floor will be 30% of inpatient covered charges or 100% of costs, whichever is less. Outpatient covered charges will be reimbursed based on payment for hospitals without cost settlement, as outlined in Attachment 4.19-B.

457. SUPPLEMENTAL PAYMENTS

01. SUPPLEMENTAL PAYMENTS FOR NON-STATE GOVERNMENT-OWNED HOSPITALS.

Subject to the provisions of this section, eligible providers of Medicaid inpatient hospital services shall receive a supplemental payment each state fiscal year. Eligible providers are nonstate government-owned and/or operated hospitals, including critical access hospitals.

The supplemental payments are intended to be used to improve access to health care. The payments made to these facilities will be based on the aggregate difference in the actual amount paid by the Medicaid program and the amount that would have been paid under Medicare payment principles using a cost basis method.

Supplemental payments made to the non-state governmental-owned hospitals that provide inpatient hospital services will be distributed to all hospitals within that group based on a hospital's percentage of Medicaid inpatient days to total inpatient days within the group.

The supplemental payments made to non-state government-owned and/or operated hospitals are subject to prior federal approval and a contractual commitment by the