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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 09-014-B

This file contains the following documents in the order listed:

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification

MAY 1 1 2010

Richard Armstrong, Director
Department of Health & Welfare
Towers Building – Tenth Floor
PO Box 83720
Boise, Idaho 83720-0036

RE: Idaho SPA TN# 09-014B

Dear Mr. Armstrong,

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 09-014B. This amendment represents a complete rewrite of Attachment 4.19-D for ICF/MRs, and freezes ICF/MR per diem rates for SFY 2010 to the rates in place on June 30, 2009.

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 09-014B is approved effective as of July 12, 2009. For your files, we are enclosing the HCFA-179 transmittal form and the amended plan pages.

If you have any questions concerning this state plan amendment, please contact Tom Couch, CMS' Boise Outstation Office, at 334-9482 or Thomas.Couch@cms.hhs.gov .

Sincerely,

[redacted]

Cindy Mann
Director
Center for Medicaid, CHIP, and Survey & Certification

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: **09-014B(pti)**

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
July 12, 2009

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:
42 CFR 447.201

7. FEDERAL BUDGET IMPACT:
Total ($) Federal Funds
FFY 2009 ($62,000), FFY 2010 ($186,588)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, pages 28-47

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Pages. 28-60
Attachment 4.19-D, with Appendices A- F
Attachments II, III, IIIV(IV), V (pti)

10. SUBJECT OF AMENDMENT:
We are requesting this amendment to our State Plan to remove all outdated reimbursement methodologies, condense the existing reimbursement methodology explanation for ICF/MRs to a high-level definition, and cite Idaho Code and Idaho Administrative Rules for further reimbursement methodology explanation. We are freezing daily rate reimbursement increases for ICF/MR for one year from 7/1/09 through 6/30/10.

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 OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME:
Leslie M. Clement

14. TITLE:
Administrator

15. DATE SUBMITTED: 2-22-2010

16. RETURN TO:
Leslie M. Clement, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0036

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: FEB 2 2 2010

18. DATE APPROVED: 5-11-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 1 2 2009

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMCS

23. REMARKS:

4-14-10 - State authorized pen + ink changes

FORM HCFA-179 (07-92)

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR)

I. Introduction

Except as otherwise provided in this section, intermediate care facilities for the mentally retarded, shall remain at the rate paid in state fiscal year 2009 through June 30, 2010. Thereafter, intermediate care facilities for the mentally retarded shall be reimbursed based on a prospective rate system.

01. Rate setting principles and methods for ICF/MR is contained in Idaho Administrative Code 16.03.10.588-621 (effective 3/19/07), 16.03.10.622 (effective 7/1/09) and 16.03.10.623-633 (effective 3/19/07).

- Idaho's methodology is a cost-based prospective reimbursement system. New rates are effective July 1st of each year and rebased annually.
- 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.
- Reimbursement rates will be set based on the most recently audited cost data from cost reports and audit reports.

02. Data Sources used by the Department of Health and Welfare, Division of Medicaid are the following:

a. Year end reports which contain historical financial and statistical information submitted by the facility for past rate-setting years.
b. Utilization and payment history report.

II. Development of the Rate

01. Providers of ICF/MR facilities will be paid a per diem rate which, with certain exceptions, is not subject to an audit settlement.

02. The per diem rate for a fiscal period will be based on audited historical costs adjusted for inflation.

03. Total payment will include the following components:

    a. Property reimbursement
    b. Capped costs
    c. An efficiency increment
    d. Exempt costs
    e. Excluded costs

III. Allowable Costs

01. **Accounts Collection**. The costs related to the collection of past due program related accounts, such as legal and bill collection fees, are allowable.

02. **Auto and Travel Expense**. Maintenance and operating costs of a vehicle used for patient care purposes and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement can not exceed the amount determined reasonable by the Internal Revenue Service for the period being reported. Meal reimbursement is limited to the amount that would be allowed by the state for a state employee.

03. **Bad Debts**. Payments for efforts to collect past due Title XIX and Title XXI accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX and Title XXI coinsurance amounts are one hundred percent (100%) reimbursable as provided in PRM, Section 300.

04. **Bank and Finance Charges**. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable.

05. **Compensation of Owners**. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are actually performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation cannot exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation cannot exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in IDAPA 16.03.10.597 (Effective 3/19/07). In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following:

    a. Salaries, wages, bonuses and benefits which are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period.
    b. Supplies and services provided for the owner's personal use.
    c. Compensation paid by the facility to employees for the sole benefit of the owner.
    d. Fees for consultants, directors, or any other fees paid regardless of the label.
    e. Keyman life insurance.
    f. Living expenses, including those paid for related persons.

06. **Contracted Service**. All services which are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility.

07. **Depreciation**. Depreciation on buildings and equipment is an allowable property expense subject to Section VI. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset. The depreciable life of an asset may not be shorter than the useful life prescribed at IDAPA 16.03.10.288.04 (f) (Estimated Useful Lives of Depreciable Hospital Assets, 2004 revised edition).

08. **Dues, Licenses and Subscriptions**. Subscriptions to periodicals related to patient care and for general patient use are allowable. Fees for professional and business licenses related to the operation of the facility are allowable. Dues, tuition, and educational fees to promote quality health care services are allowable when the provisions of PRM, Section 400, are met.

09. **Employee Benefits**. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics.

10. **Employee Recruitment**. Costs of advertising for new employees, including applicable entertainment costs, are allowable.

11. **Entertainment Costs Related to Patient Care**. Entertainment costs related to patient care are allowable only when documentation is provided naming the individuals and stating the specific purpose of the entertainment.

12. **Food**. Costs of raw food, not including vending machine items, are allowable. The provider is only reimbursed for costs of food purchased for patients. Costs for non-patient meals are non-reimbursable. If the costs for non-patient meals cannot be identified, the revenues from these meals are used to offset the costs of the raw food.

13. **Home Office Costs**. Reasonable costs allocated by related entities for home office services are allowable in their applicable cost centers.

14. **Insurance**. Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care.

15. **Interest**. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable.

16. **Lease or Rental Payments**. Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, will be reimbursed in the same manner as an owned asset. The cost of leases related to home offices and ICF/MR day treatment services will not be reported as property costs and will be allowable based on reasonable cost principles subject to other limitations contained herein.

17. **Malpractice or Public Liability Insurance**. Premiums for malpractice and public liability insurance must be reported as administrative costs.

18. **Payroll Taxes**. The employer's portion of payroll taxes is reimbursable.

19. **Property Costs**. Property costs related to patient care are allowable subject to other provisions of this attachment. Property taxes and reasonable property insurance are allowable for all facilities. For ICFs/MR, the property rental rate is paid as described in Section VI.

    a. Amortization of leasehold improvements will be included in property costs.
        i. Straight line depreciation on fixed assets is included in property costs.
        ii. Depreciation of moveable equipment is an allowable property cost.

    b. Interest costs related to the purchase of land, buildings, fixtures or equipment related to patient care are allowable property costs only when the interest costs are payable to unrelated entities.

20. **Property Insurance**. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class at the end of a facility's fiscal year.

21. **Repairs and Maintenance**. Costs of maintenance and minor repairs are allowable when related to the provision of patient care.

22. **Salaries**. Salaries and wages of all employees engaged in patient care activities or operation and maintenance are allowable costs. However, non-nursing home wages are not an allowable cost.

23. **Supplies**. Cost of supplies used in patient care or providing services related to patient care is allowable.

24. **Taxes**. The costs of property taxes on assets used in providing patient care are allowable. Other taxes are allowable costs as provided in the PRM, Chapter 21. Tax penalties are non-allowable costs.

IV. Non-Allowable Cost

01. **Accelerated Depreciation**. Depreciation in excess of calculated straight depreciation, except as otherwise provided.

02. **Acquisitions**. Costs of corporate acquisitions, such as purchase of corporate stock as an investment.

03. **Barber and Beauty Shops**. All costs related to running barber and beauty shops.

04. **Charity Allowances**. Cost of free care or discounted services.

05. **Consultant Fees**. Costs related to the payment of consultant fees in excess of the lowest rate available to a facility. It is the provider's responsibility to make efforts to obtain the lowest rate available to that facility. The efforts may include personally contacting possible consultants or advertising. The lowest rate available to a facility is the lower of the actual rate paid by the facility or the lowest rate available to the facility, as determined by departmental inquiry directly to various consultants. Costs in excess of the lowest rate available will be disallowed effective thirty (30) days after a facility is notified, unless the provider shows by clear and convincing evidence it would have been unable to comply with state and federal standards had the lowest rate consultant been retained or that it tried to but was unable to retain the lowest rate consultant.

06. **Fees**. Franchise fees.

07. **Fund Raising**. Certain fund-raising expenses.

08. **Goodwill**. Costs associated with goodwill.

09. **Holding Companies**. All home office costs associated with holding companies.

10. **Interest**. Interest to finance non-allowable costs.

11. **Medicare Costs**. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services.

12. **Non-patient Care Related Activities**. All activities not related to patient care.

13. **Organization**. Organization costs.

14. **Pharmacist Salaries**. Salaries and wages of pharmacists.

15. **Prescription Drugs**. Prescription drug costs.

16. **Related Party Interest**. Interest on related party loans.

17. **Related Party Non-allowable Costs**. All costs non-allowable to providers are non-allowable to a related party, whether or not they are allocated.

18. **Related Party Refunds**. All refunds, allowances, and terms, will be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc.

19. **Self-Employment Taxes**. Self-employment taxes, as defined by the Internal Revenue Service (IRS), which apply to facility owners.

20. **Telephone Book Advertising**. Telephone book advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in.

21. **Vending Machines**. Costs of vending machines and cost of the product to stock the machine.

V. Property Costs.

01. Idaho Medicaid will reimburse ICF/MR Property costs by a rental rate or based on cost.

02. The following will be reimbursed based on cost. ICF/MR living unit property taxes, ICF/MR living unit property insurance, and major movable equipment not related to home office or day treatment services.

03. Reimbursement of other property costs is included in the property rental rate.

04. Any property cost related to home offices and day treatment services are not considered property costs and will not be reported in the property cost portion of the cost report. Facilities will report these costs in the home office and day treatment section of the cost report.

05. Property costs, including those based on a rental rate, will be reported in the property cost portion of the cost report. The Department may require and utilize an appraisal to establish those components of property costs identified as an integral part of an appraisal.

06. Property costs include the following components:

    a. Depreciation. Allowable depreciation based on straight line depreciation.
    b. Interest. All allowable interest expense which relates to financing depreciable assets. Interest on working capital loans is not a property cost and is subject to the cap.
    c. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances are not property costs.
    d. Lease Payments. All allowable lease or rental payments.
    e. Property Taxes. All allowable property taxes.
    f. Costs of Related Party Leases. Costs of related party leases are to be reported in the property cost categories based on the owner's costs.

VI. Property Rental Rate Reimbursement

ICFs/MR will be reimbursed a property rental rate. Property taxes, property insurance, and depreciation expense or major moveable equipment will be reimbursed as costs exempt from limitations. The property rental rate does not include compensation 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. See Sections 56-108 and 56-109, Idaho Code (effective 7/1/09), for further clarification.

01. **Property Rental Rate**. The property rental rate is based upon current construction costs, the age of the facility, the type of facility, and major expenditures made to improve the facility, or a rate based upon property costs as of January 1, 1985. The amount paid for each Medicaid day of care will be phased in according to the following:

    a. The amount paid for each Medicaid day of care is R = "Property Base" x 40 - "Age" / 40 x "change in building costs", as defined in IDAPA 16.03.10.630.01 (effective 3/19/07).
    b. In the event that new requirements are imposed by state or federal agencies, the Department will reimburse the expenditures directly related to these requirements as an increase in the property rental rate if the expense is in excess of one hundred dollars ($100) per bed. If the cost related to the requirement is less than one hundred dollars ($100) per bed, the Department will, within twelve (12) months of verification of expenditure, reimburse the Medicaid share of the entire cost of such new requirements, as a one (1) time payment to the facility.
    c. At no time will the property rental rate paid to a facility be less than the greater of the rate allowable to that facility on December 31, 1988, the rate allowable immediately following the first opening of a new facility after December 31, 1988, or the rate allowable immediately following the last, if any, age revision after December 31, 1988.

02. **Sale of a Facility**. In the event of the sale of a facility, or asset of a facility, the buyer will receive the property rental rate of Section VI.01.

VII. Costs.

This Section defines items and procedures to be followed in determining allowable and exempt costs and provides the procedures for extracting cost data from historical cost reports, applying a cost forecasting market basket to project costs forward, procedures to be followed to project costs forward, and procedures for computing the median of the range of costs and the ICF/MR cap.

01. **Costs Subject to the Cap**. Items subject to the cap include all allowable costs except property costs identified in Section V. and exempt costs or excluded costs identified in Section X or XI.

02. **Home Office Costs**. Home office costs are administrative costs and will not be reported as property costs.

03. **Per Diem Costs**. Costs to be included in this category are divided by the total participant days for the facility for the cost reporting period to arrive at allowable per diem costs. If costs for services provided some or all non-Medicaid residents are not included in the total costs submitted, the provider must determine the costs and combine them with the submitted costs in order that a total per diem cost for that facility can be determined for both purposes of determining the ICF/MR cap and of computing final reimbursement.

04. **Cost Data to Determine the Cap**. Cost data to be used to determine the cap for ICF/MR facilities will be taken from each provider's most recent final cost report available sixty (60) days before the beginning of the period for which the cap is being set. Cost reports are final when the final audit report is issued, or earlier if the Department informs the facility the report is final for rate setting purposes. The selected final cost report will be used to establish the facility's prospective reimbursement rate. However, the final cost reports covering a period of less than twelve (12) months will be included in the data for determining the cap at the option of the Department.

05. **Projection**. Per Diem allowable costs will be inflated forward, using the Idaho specific inflation index from the Skilled Nursing Facility Market Basket as established by Global Insights Inc., or its successor and forecasting indices according to the same table as used for free standing facilities.

    a. The inflation method, using the Idaho specific inflation index from the Skilled Nursing Facility Market Basket as established by Global Insights Inc., or its successor, used in Section VII.07 to set the cap will also be used to set non property portions of the prospective rate which are not subject to the cap.
    b. Forecasting indices, using the Idaho specific inflation index from the Skilled Nursing Facility Market Basket as established by Global Insights Inc., or its successor, will be used unless they are unavailable. In such case, indices supplied by some other nationally recognized forecaster will be used.

06. **Costs Which Can be Paid Directly by the Department to Non ICF/MR Providers**. Costs which can be paid directly by the Department to non ICF/MR providers are excluded from the ICF/MR prospective rates and ICF/MR cap:

    a. Direct physician care costs. Physicians who provide these services must bill the Medicaid program directly using their own provider numbers.
    b. Costs of services covered under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) portion of the Medicaid Program. Items such as eyeglasses and hearing aids are covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." Dental services provided to EPSDT participants who are under the age of twenty-one (21) and who reside in an ICF/MR, are covered under Idaho Administrative Code, Section 16.03.10.80-85. The cost of these services is not includable as a part of ICF/MR costs. Reimbursement is made to a professional providing these services through his billing the Medicaid Program on his own provider number.
    c. Costs of services covered by other parts of the Medicaid Program. Examples of these items include legend drugs and ambulance transportation. These items are to be billed to the Medicaid Program directly by the provider using his own provider number.

07. Cost Projection. Allowable per diem costs will be projected forward from the midpoint of the Base Period to the midpoint of the Target Period. "Base Period" is defined as the last available final cost report period. "Target Period" is defined as the effective period of the prospective rate. Procedures for inflating these costs are as follows:

a. The percentage change for each cost category in the market basket (using the Idaho specific inflation index from the Skilled Nursing Facility Market Basket as established by Global Insights Inc. or its successor) will be computed from the beginning to the end of the Base Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward allowable per diem costs for each cost category from the midpoint to the end of the Base Period.

b. The percentage change for each cost category in the market basket (using the Idaho specific inflation index from the Skilled Nursing Facility Market Basket as established by Global Insights Inc. or its successor) will be computed for the period from the end of the Base Period to the beginning of the Target Period. These percentages will then be used to project forward the allowable per diem costs for each cost category, as determined in Section VII.07.a from the end of the Base Period to the beginning of the Target Period.

c. The percentage change for each cost category in the market basket (using the Idaho specific inflation index from the Skilled Nursing Facility Market Basket as established by Global Insights Inc. or its successor) will be computed for the beginning to the end of the Target Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward the allowable per diem costs as determined in Section VII.07.b from the beginning to the midpoint of the Target Period.

08. **Cost Ranking**. Prior to October 1st of each year the Director will determine the percent above the median which will assure aggregate payments to ICF/MR providers will approximate but not exceed amounts that would be incurred using Medicare cost principles of reimbursement. That percentage will apply to caps and rates set after September 30th of each year. Projected per diem costs as determined in this section and subject to the cap will be ranked from the highest to the lowest. The cap will be set at a percent of the bed-weighted median for each rate period. The initial cap will be set as of October 1, 1996.

    a. The median of the range will be computed based on the available data points being considered as the total population of data points.
    b. The cap for each ICF/MR facility with a fiscal year beginning October 1, 1996, will be computed prior to the beginning of that year. For those facilities with a fiscal year ending on a date other than September 30th, the first cap will be computed for the period beginning October 1, 1996, and ending on the fiscal year end date.
    c. Facilities with cost reports that transcend the period from October 1, 1996, through September 30, 1997, will be retrospectively settled using the previous reimbursement system for the period of the report up to September 30, 1996. There will not be a retrospective settlement on the portion of these cost reports attributed to October 1, 1996 through the end of the cost report period unless provisions in Section XI apply.
    d. Cost reports for periods beginning on or after October 1, 1996, will not be subject to retrospective settlement except as required by other provisions of this chapter.
    e. A new cap and rate will be set on an annual basis for each facility the first of July every year.
    f. The cap and prospective rate will be determined and set on an annual basis for each facility July 1st of every year and will not be changed by any subsequent events or information with the exception that if the computations were found to contain mathematical or clerical errors, these errors will be corrected and the cap will be adjusted using the corrected figures.
    g. Payment of costs subject to the cap will be limited to the cap unless the Department determines the exclusions found in Section XI are applicable.
    h. A facility which commences to offer participant care services as an ICF/MR on or after October 1, 1996, will be subject to retrospective settlement until the first prospective rate is set. Such facility will be subject to the ICF/MR cap as determined in this chapter. The first prospective rate for this provider will be set by the Department based on quarterly cost statements and final cost reports submitted for periods following the first three (3) months of operation. This first prospective rate may be set after the beginning of the second fiscal year of the provider. For the second year the provider will be paid a rate to be settled retrospectively unless both the Department and the provider agree to a prospective rate or rates covering that fiscal period.

VIII. Efficiency Increment. An efficiency increment will be included as a component of the prospective rate, or retrospective settlement if the allowable capped per diem costs are less than the cap.

01. **Computing Efficiency Increment**. The efficiency increment will be computed by subtracting the projected or, for facilities subject to retrospective settlement the actual allowable per diem costs incurred by the provider, from the applicable cap. This difference will be divided by five (5). The allowable increment is twenty cents ($.20) per one dollar ($1) below the cap up to a maximum increment of three dollars ($3) per participant day.

02. **Determining Reimbursement**. Total reimbursement determined by adding amounts determined to be allowable, will not exceed the provider's usual and customary charges for these services as computed in accordance with this chapter and PRM. In computing participant days for the purpose of determining per diem costs, in those cases where the Medicaid Program or the participant is making payment for holding a bed in the facility, the participant will not be considered to be discharged and thus those days will be counted in the total.

IX. **Retrospective Settlement.** When retrospective settlement is applicable, it is based on allowable reimbursement and will be subject to the same caps and limits determined for prospective payments. Retrospective settlement will be based on an audit report.

01. **A Provider's Failure to Meet Any of the Conditions**. A provider's failure to meet any of the conditions of participation set forth in 42 CFR 483, Subpart I, may subject that provider to retrospective reimbursement for the fiscal year, or any portion thereof, during which the condition is not met. The provider's projected per diem rate may be adjusted to reflect actual reimbursable costs subject to cost limits.

02. **A First Time Provider**. A first time provider operating a new ICF/MR living unit will be subject to a retrospective settlement for the first fiscal year and until the first subsequent period wherein a prospective rate is set. A budget based on the best available information is required prior to opening for participant care so an interim rate can be set.

03. **New ICF/MR Living Unit.** A new ICF/MR living unit for an existing operator is subject to first time facility requirements if the new living unit reflects a net increase in licensed beds, otherwise the Department may set a prospective rate with the non-property rate components based on similar components of rates most recently paid for the participants moving into the facility. The property rental rate will be set according to applicable provisions of this chapter.

04. **Change of Ownership of Existing ICF/MR Living Unit**. Where there is a change of ownership of an existing ICF/MR living unit, the provider operating the ICF/MR living unit will not receive an adjustment of the provider's prospective rate except that the property rental portion of the rate will be adjusted subject to property rental provisions of this chapter. However, new facility reporting requirements and the cap will apply.

05. **Fraudulent or False Claims**. Providers who have made fraudulent or false claims are subject to **retrospective** settlement as determined by the Department.

06. **Excluded Costs**. Excluded costs may be retrospectively settled.

X. Exempt Costs. Exempt costs are not subject to the ICF/MR cap.

01. **Day Treatment Services.** As specified in this Section, the cost of day treatment services may be reimbursed in this category and may not be subject to the ICF/MR cap.

a. This category includes the direct costs of labor, benefits, contracted services, property, utilities and supplies for such services up to the limitations provided in this Subsection.
b. When a school or another agency or entity is responsible for or pays for services provided to a participant regularly during normal working hours on weekdays, no costs will be assigned to this category for such services. The Department will not reimburse for the cost of services which are paid for or should be paid for by another agency.
c. When ICF/MR day treatment services are performed for participants in a licensed Developmental Disability Center, the allowable cost of such services will be included in this category, but not more than the amount that would be paid according to the Department's fee schedule for individual or group therapy for similar services. Amounts incurred or paid by the ICF/MR in excess of what would be paid according to the Department's fee schedule for like services are not allowable costs and will be reported as non-reimbursable.
d. For day treatment services provided in a location other than a certified developmental disability center, the maximum amount reportable in this category will also be limited. Total costs for such services reported by each provider in this category will be limited to the number of hours, up to thirty (30) hours per week per participant, of individual or group developmental therapy times the hourly rate that would be paid according to the most recent Department fee schedule for the same services if provided in a developmental disability center. Costs in excess of the limits determined in this Subsection will be classified and reported as subject to the ICF/MR cap. Initial rates established under the prospective system effective October 1, 1996, and not later than October 1, 1997, will not include a limitation of day treatment costs based on the hourly rate, when the hours of individual or group therapy were not obtained or audited by the Department at the time the rate was published. However, if a provider believes that the day treatment cost used to establish the day treatment portion of its prospective rate was misstated for rates set for periods beginning October 1, 1996, through rates beginning October 1, 1997, revisions to the prospective rate may be made to the extent the provider demonstrates, to the satisfaction of the Department, that the cost used was misstated. Such a revision will be considered only if the provider requests a revision and provides adequate documentation within sixty (60) days of the date the rate was set. At the option of the Department it may negotiate fixed rates for these day treatment services. Such rates will be set so the aggregate related payments are lower than would be paid with a limitation based on schedules used for licensed Developmental Disability Centers.

e. Financial data including expenses and labor hours incurred by or on behalf of the provider in providing day treatment services must be identifiable and separate from the costs of other facility operations. Reasonable property costs related to day treatment services and not included in the property rental rate, will be separately identified, will be reported as day treatment services costs, and will not include property costs otherwise reimbursed. Property costs related to day treatment services will be separately identified as not related to living unit costs by a final audit determination issued prior to October 1, 1996, or will be separate and distinct from any property used for ICF/MR services which are or were day treatment services.

f. In the event a provider has a change in the number of participants requiring day treatment services, the prospective rate may be adjusted by the Department to reflect a change in costs related to such a change. Providers receiving such changes may be required to provide added documentation to the Department to assure that further changes can be identified and the prospective rate adjusted accordingly.

02. **Major Movable Equipment**. Costs related to major movable equipment, as defined in this chapter will be exempt from the ICF/MR cap and will be reimbursed prospectively based on Medicare principles of cost reimbursement.

XI. **Costs Excluded from the Cap.** Certain costs may be excluded from the ICF/MR cap, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective payment rate to assure equitable reimbursement.

01. **Increases of More Than One Dollar Per Participant Day in Costs**. Increases of more than one dollar ($1) per participant day in costs otherwise subject to the cap incurred by a facility as a result of changes in State or Federal laws or rules will be reported separately on the cost report for reports filed less than thirty (30) months, or a greater length of time if so directed by the Department, from the date such increases were first required. Such costs will be subdivided into the component parts of wages, benefits, contracted services and other costs in the amounts equal to costs removed from the respective cost categories subject to the cap. The Department may adjust the forecasted rate to include the projected per diem related to such costs.

a. The provider will report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger.

b. If more than one (1) increase occurs as a result of one (1) or more law or rule change, the costs from each event are to be reported separately.

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise.

d. For interim rate purposes the provider's prospective rate may be granted an increase to cover such cost increases. A cost statement covering a recent period may be required with the justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled.

e. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at its option, include all of the previously excluded costs related to those increases with costs subject to the cap when setting rates or increase the cap and individual facility prospective rates following such cost increases. If a cap is set with these particular costs included in the cap category, providers subject to that cap will not have these costs excluded from the cap for prospective rate purposes. The intent of this provision is for costs to be exempt from the cap until these costs are able to be fully and equitably incorporated in the data base used to project the cap and for these costs to be exempt only when they are not included in the data base. In those cases, when costs are not incurred immediately after a change in rule or law, delays in incorporating the new costs in the cap are warranted.

f. When cost increases which have been excluded from the cap are incorporated in the inflation indices used to set the cap, the cost indices will be adjusted to exclude the influence of such changes if the amount included in the index is identified. When the cap is set to include previously excluded amounts, any adjustments previously made to the indexes related to the previously excluded costs will be removed.

02. **Excess Inflation**. Reimbursement of costs subject to the cap will be limited to the cap unless the Department determines the inflation indices used to set the prospective rates for a reporting period understated actual inflation by more than seven (7%) percentage points. In such case, prospective rates and the cap will be increased by the amount which actual inflation indices exceeded projected inflation indices and may be retrospectively adjusted by the Department.

03. **Cost Increases Greater Than Three Percent**. When cost increases of greater than three percent (3%) of the projected interim rate which result from disasters such as fire, flood, or earthquake, epidemic or similar unusual and unpredictable circumstances over which a provider has no control, prospective rates will be increased and they will not be subject to the cap. However, they may be retrospectively adjusted by the Department. For the purposes of this Subsection, disaster does not include personal or financial problems.

04. **Decreases**. In the event of state or federal law, rule, or policy changes which result in clearly identifiable reductions in required services, the Department may reduce the prospective rate to reflect the identified per diem amount related to such reductions.

05. **Prospective Negotiated Rates**. The Director will have the authority to negotiate prospective rates for providers who would otherwise be subject to accept retrospective settlement. Such rates will not exceed the projected allowable rate that would otherwise be reimbursed based on provisions of this State Plan.

XII. ICF/MR – Special Rates. Section 56-117, Idaho Code, provides that the Department may pay facilities a special rate for care given to participants who have medical or behavior long-term care needs beyond the normal scope of facility services. These participants must have one (1) or more of the following behavior needs: additional personnel for supervision, additional behavior management, or additional psychiatric or pharmacology services. A special rate may also be given to participants having medical needs that may include but are not limited to participants needing ventilator assistance, certain medical pediatric needs, or participants requiring nasogastric or intravenous feeding devices. These medical and behavior needs are not adequately reflected in the rates calculated pursuant to the principles set in Section 56-113, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this State Plan section and will be based on a per diem rate applicable to the incremental additional costs incurred by the facility. Payment for special rates will start with approval by the Department and be reviewed at least yearly for continued need. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of Section XII, will be excluded from the computation of payments or rates under other provisions of Sections 56-102, Idaho Code, IDAPA Code 16.03.09, "Medicaid Basic Plan Benefits," and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits."

01. **Determinations.** A determination to approve or not approve a special rate will be made on a participant by participant basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source.
02. **Approval.** Special rates will not be paid unless prior authorized by the Department. A special rate may be used in the following circumstances:
    a. New admissions to a community ICF/MR;
    b. For participants currently living in a community ICF/MR when there has been a significant change in condition not reflected in the current rate; or
    c. The facility has altered services to achieve and maintain compliance with state licensing or federal certification requirements that have resulted in additional cost to the facility not reflected in their current rate.
    d. An emergency exists when the facility must incur additional behavioral or medical costs to prevent a more restrictive placement.
03. **Reporting**. Costs equivalent to payments at the special rate will be removed from the cost components subject to limits, and will be reported separately.
04. **Limitations**. The reimbursement rate paid will not exceed the provider's charges to other participants for similar services.

XIII. Reimbursement Provisions for State Owned Or Operated ICF/MR Facilities.

Reimbursement to ICF/MR facilities owned or operated by the state of Idaho will be governed by the principles set forth in the PRM, with the exception of depreciation. Assets of such facilities need not be depreciated if they have an acquisition or historical cost of less than five thousand dollars ($5,000).