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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 12-011

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 and CHIP Services (CMCS)

DEC 19 2012

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

RE: Idaho SPA TN# 12-011

Dear Mr. Armstrong,

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 12-011. This amendment separates the reimbursement of behavioral care units (BCUs) from the routine nursing facility (NF) reimbursement system.

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 12-011 is approved effective as of October 1, 2012. 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, CMCS

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: **12-011**

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
October 1, 2012

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(a)(6), 1905(a)(12) and 2110(a)(24) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
Total ($) Federal Funds
~~FFY 2013 ($0)~~ **FFY 2014 ($0)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, pages 1,3,4,15,20,21,22, and 23
Attachment 4.19-D, pages 15a (new page)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D, pages 1,3,4,15,20,21,22, and 23

10. SUBJECT OF AMENDMENT:
This proposed change to reimbursement will define payment to a new Behavioral Care Unit (BCU) in Nursing Facilities. It is also being made to continue benefits. The Department must be able to continue to calculate reimbursement rates based on current cost reporting years and those years have to be defined.

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:

[redacted]

13. TYPED NAME:
Paul J. Leary

14. TITLE:
Administrator

15. DATE SUBMITTED: 9.4.12

16. RETURN TO:

Paul J. Leary, 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: October 4, 2012

18. DATE APPROVED: December 19, 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2012

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Carol J.C. Peverly

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health Operations

23. REMARKS:

11/14/2012 - Pen and Ink (P&I) changes authorized by State to block #7.

FORM HCFA-179 (07-92)

STATE PLAN FOR MEDICAID PROVIDER REIMBURSEMENT
Long Term Care Services

Nursing facilities (NF) and intermediate care facilities for the intellectually disabled (ICF/ID) are paid for Medicaid recipients by means of rates determined in accordance with the following principles, methods and standards which comply with 1902(a)(13)(A), 1902(a)(13)(B), 1902(a)(13)(C), 1913(b), and 1902(a)(30) of the Social Security Act and Federal Regulations at 42 CFR 447 Subpart C, 42 CFR 447.250 through .252, .253, .255, .256, .257, .272, and .280. Rate setting principles and methods for Nursing Facility care and ICF/ID care is contained in Idaho Statute 56-101 through 56-135 effective 7/1/2009.

NURSING FACILITY

I. **Introduction**

01. Rate setting principles and methods for Nursing Facility care is contained in Idaho Administrative Code 16.03.10.257-258 (effective 7/1/10) and 16.03.10.235-256 and 259.296 (effective 3/19/07).
    - Idaho's methodology is a cost-based prospective reimbursement system with an acuity adjustment for direct care costs. New rates are effective July 1st of each year and rebased annually with quarterly adjustments for case mix.
    - 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 projected cost data from cost reports and audit reports.
    - Reimbursement is to be set for freestanding and hospital-based facilities.
    - Rate adjustments are made quarterly based on each facility's case mix index as of a certain date during the preceding quarter. Reference section II.01 on page 2 of Attachment 4.19-D.
    - For the rate period July 1, 2011 through June 30, 2012. Rates will be calculated using cost reports ended in calendar period2010 with no allowance for inflation to the rate year of July 1, 2011, through June 30, 2012.
    - For the rate years beginning October 1, 2012, and annually thereafter, rates will be calculated using audited cost reports for periods ended in the preceding calendar year with no allowance for inflation to the prospective rate period.

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.
    c. Medicare Cost report.

04. **Direct Care Cost Component**. The direct care cost component of a nursing facility's rate is determined as follows:

a. The direct care per diem cost limit applicable to the rate period for the four nursing facility categories: 1) free-standing and urban hospital-based nursing facilities, 2) rural hospital-based nursing facilities, 3) free standing and hospital-based behavioral care unit, 4) rural hospital-based behavioral care unit is identified. The identified direct care cost limit is divided by the statewide average CMI for the cost reporting period, and then multiplied by the nursing facility's facility-wide CMI for the cost reporting period to derive the adjusted direct care per diem cost limit.

b. The adjusted direct care per diem cost limit is compared to the nursing facility's inflated direct care per diem costs. The lower of the two (2) amounts is then case mix adjusted.

i. If the adjusted direct care per diem cost limit is lower, the adjusted limit is divided by the nursing facility's facility-wide CMI for the cost reporting period, and then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period to arrive at the direct care cost component.

ii. If the inflated direct care per diem costs are lower, these costs, minus raw food and Medicaid related ancillary costs, are divided by the nursing facility's facility-wide CMI for the cost reporting period, then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period. Raw food and Medicaid related ancillary costs are then added back to arrive at the direct care cost component.

05. Indirect Care Cost Component. The indirect care cost component of a facility's rate is the lesser of the facility's inflated indirect care per diem costs or the indirect per diem cost limit for that type of provider -- free-standing and urban hospital-based nursing facilities including behavioral care unit nursing facilities, or rural hospital-based nursing facilities including behavioral care unit nursing facility providers.

The following are indirect care costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM:

A. Activities
B. Administrative and general care costs
C. Dietary (non-"raw food" costs)
D. Employee benefits associated with the indirect salaries
E. Housekeeping
F. Laundry and linen
G. Medical records
H. Other costs not included in direct care costs, or costs exempt from cost limits
I. Plant operations and maintenance (excluding utilities)

The indirect cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with freestanding and hospital based nursing facilities included in the same array, and the bed-weighted median will be computed.

Increases or decreases in the direct and indirect cost limits will be determined by the limitations calculated in the most recent base year, indexed forward each year from the midpoint of the base year to the midpoint of the rate year by the inflation factor (provided by Global Insights Inc.,) plus one percent (1%) per annum. The calculated direct and indirect cost limits will not be allowed to decrease below the limitations effective in the base year. The following defines the first year (2000) Indirect Cost Component:
The indirect cost component rate calculation is based on a percentage above the median. Freestanding Skilled Nursing Facilities (SNFs), Urban Hospital-Based: Direct: 128% above the median; Indirect: 123.25% above the median. Rural Hospital-Based: Direct: 155% above the median; Indirect: 147.25% above the median.

The maximum rate of growth on the cost limits, and the minimum cost limitation, and the period of their use will be examined and agreed upon by the nursing facility oversight committee who consists of representatives from the Department, the state association(s) representing freestanding nursing facilities, and the state association(s) representing hospital-based nursing facilities. The caps will not increase faster than the rate of inflation, Global Insights inc., (successor of DRI), plus an economically feasible addition not to exceed 1%.

VII. Cost Limits Based on Cost Report. Each July 1st cost limitations will be established for nursing facilities based on the most recent audited cost report. Calculated limitations will be effective for a one (1) year period, from July 1st through June 30th, which is the rate year. For rate years beginning October 1, 2012, and annually thereafter, the direct and indirect cost limits will be calculated using the most recent audited cost reports adjusted to the midpoint of each provider's cost reporting year that is used to set the July 1 rate, to allow for no inflation to the rate year.

01. **Percentage above Bed-Weighted Median**. Prior to establishing the first "shadow rates" at July 1, 1999, the estimated Medicaid payments under the previous retrospective system for the year period from July 1, 1999, through June 30, 2000, will be calculated. This amount will then be used to model the estimated payments under the case mix system set forth in Section II. The percentages above the bed-weighted median, for direct and indirect costs, will be established at a level that approximates the same amount of Medicaid expenditures as would have been produced by the retrospective system. The percentages will also be established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the retrospective system. Once the percentage is established, it will be used to calculate the limit by multiplying the bed-weighted median per diem direct cost times the calculated percentage for that class of provider. There will be a direct and indirect percentage that is applied to freestanding and urban hospital-based nursing facilities, and a higher direct and indirect percentage that is applied to rural hospital-based nursing facilities. Beginning with rates effective October 1, 2012, additional direct care cost limit categories will be added for free-standing and urban hospital-based behavioral care units and rural hospital-based behavioral care units. Percentages previously established for other provider class types not considered a behavioral care unit will remain unchanged. Once established these percentages will remain in effect for future rate setting periods.

02. **Direct Cost Limits**. The direct cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment (using the Idaho specific inflation index from the Skilled Nursing Facility Market Basket as established by Global Insights Inc., or its successor) from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be normalized and arrayed from high to low, all nursing facilities included in the same array, and the bed-weighted median will be computed.

03. **Indirect Cost Limits**. The indirect cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment (using the Idaho specific inflation index from the Skilled Nursing Facility Market Basket as established by Global Insights Inc., or its successor) from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with freestanding and hospital-based nursing facilities included in the same array, and the bed-weighted median will be computed.

04. **Limitation on Increase or Decrease of Cost Limits**. Increases in the direct and indirect cost limits will be determined by the limitations calculated in the most recent base year, indexed forward each year from the midpoint of the base year to the midpoint of the rate year by the inflation factor adjustment (using the Idaho specific inflation index from the Skilled Nursing Facility Market Basket as established by Global Insights Inc., or its successor) plus one percent (1%) per annum. The calculated direct and indirect cost limits will not be allowed to decrease below the limitations effective in the base year. The maximum rate of growth on the cost limits, and the minimum cost limitation, will be examined by the oversight committee periodically to determine which factors to use in the calculation of the limitations effective in the new base year and forward.

05. **Costs Exempt from Limitations**. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in Section XIII.

VIII. Nursing Facility: Behavioral Care Unit (BCU) and Rate Structure. Effective October 1, 2012, the additional direct care costs associated with BCU residents will remain in direct care costs subject to the direct care cost limitation. Those qualifying BCU nursing facility providers may have a direct care cost limitation higher than non-BCU nursing facility providers. BCU nursing facility providers will not receive an increased indirect care cost limitation.

01. **Determination**. The BCU must have a qualifying program and have been providing care in the BCU to behavior residents on July 1, 2011. Nursing facility providers that meet the BCU criteria will have BCU direct care costs included in direct care costs subject to the cost limit. The direct care cost limitation may be higher than a non-BCU nursing facility.
02. **BCU Routine Customary Charge**. If the cost to operate a BCU is included in a nursing facility's rate calculation, the nursing facility must report its usual and customary charge for semi-private rooms in both the BCU and general nursing facility. A weighted average routine customary charge is computed to represent the composite of all Medicaid nursing facility residents in the nursing facility based on the type of rooms they occupy, including the BCU.
03. **Prospective Rate Setting**. Beginning October 1, 2012, the direct care cost limit calculation for any special rate revenue offsets in the prior year related to one-to-one (1:1) staffing ratios, BCU, or increased staffing, will be reversed before calculating the cost limit. This revenue offset reversal excludes revenues related to special rate add-ons for ventilator-dependent or tracheostomy services. Rates will be calculated using the cost report ended in the calendar year prior to each July 1 rate setting period with the BCU's direct care costs included in direct care costs subject to the higher BCU cost limit.
04. **Rates Effective October 1, 2012**. For rates effective October 1, 2012, a nursing facility designated as a BCU during each nursing facility provider's cost report ended in calendar year 2011 must be identified.
    a. Days approved for a BCU during the 2011 cost report year must be identified.
    b. To qualify as a BCU, Medicaid BCU days identified in Subsection 266.04.a version 10.1.12 of IDAPA rule are divided by total days in the nursing facility and that calculation must equal or exceed a minimum of fifteen percent (15%).
05. **Annual Rates Beginning July 1, 2013**. For annual rates beginning July 1, 2013, once a rate has been set as provided in Subsection 266.03 version 10.1.12 of IDAPA rule, the following process will be used to determine BCU eligibility. A nursing facility must apply for BCU eligibility on an annual basis. Eligibility is determined by:
    a. BCU days, regardless of payer source are divided by the total occupied days in the nursing facility and that calculation must equal or exceed a minimum of twenty percent (20%).
    b. The BCU nursing facility provider must provide a list of all residents they believe were qualified for BCU status for the previous year;
        i. The department will select a sample of Idaho Medicaid participants from the submitted list. The nursing facility provider must send the MDS for each selected sample participant, along with related census information, and other requested information to the department. A description of participants is in 266.06 of IDAPA rule version 10.1.12.
        ii. The department will review this information to determine that the participants meet the requirements of Subsection 266.06 version 10.1.12 of IDAPA rule and calculate the percentage of BCU days to the total occupied days in the facility to determine whether the facility meets the BCU eligibility requirement in Subsection 266.05.a. version 10.1.12 of this rule.

XII. Special Rates. A special rate consists of a facility's daily reimbursement rate for a patient plus an add-on amount. Section 56-117 of Idaho Code (effective 7/1/09), provides authority for the Department to pay facilities an amount in addition to the daily rate when a patient has needs that are beyond the scope of facility services and when the cost of providing for those additional needs is not adequately reflected in the rates calculated This special rate add-on amount for such specialized care is in addition to any payments made in accordance with other provisions of this chapter and is excluded from the computation of payments or rates under other provisions in these rules.

01. **Determination**. The Department determines to approve a special rate on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request must be based on an identified condition that will continue for a period greater than thirty (30) days.

02. **Effective Date**. Upon approval, a special rate is effective on the date the application was received.

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

04. **Limitation**. A special rate cannot exceed the provider's charges to other patients for similar services.

05. **Determination of Payment for Qualifying Residents**. The special rate add-on is calculated using the following method:

a. One Hundred Percent (100%) Special Care Facility Existing July 1, 2000. If on July 1, 2000, an entire facility was a special care unit which included Medicaid residents, the facility's direct care cost per diem will not be subject to the direct care cost limit. However, the direct care costs are case mix adjusted based on the ratio of the facility's Medicaid CMI for the rate period to the facility-wide CMI for the cost reporting period.

b. The Department currently does not have a bid system in place. Equipment and non-therapy supplies not addressed in Section 225 version 03.04.11, of IDAPA 16.03.10, such as CPAP/BIPAP machines, specialized mattresses, specialized beds, specialized wheelchairs, wound VACs, wound VAC supplies, and augmentative communication devices (ACDs), as determined by the Department, are reimbursed in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits." Section 755, as an add-on amount.

c. Ventilator Dependent Residents and Residents Receiving Tracheostomy Care. In the case of residents who are ventilator dependent and who receive Tracheostomy care the special add-on amount to the facility's rate for approved residents receiving this care, is determined by combining the following two (2) components:

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

   ii. Calculation of an add-on for equipment and non-therapy supplies following the provisions in Subsection 270.06.a. version 3.19.07 of IDAPA rule.

06. **Treatment of the Special Rate Cost for Future Rate Setting Periods**. Special rates are established on a prospective basis similar to the overall facility rate. When the cost report used to set a prospective rate contains special rate cost, an adjustment is made to "offset," or reduce costs by an amount equal to total "grossed up" incremental revenues, or add-on payments received by the provider during the cost reporting period. The amount received is calculated by multiplying the special rate add-on amount paid for each qualifying resident by the number of days that were paid. This calculated Medicaid amount will be "grossed up" by dividing the Medicaid incremental revenue by Medicaid days and multiplying the result by total patient days. No related adjustment is made to the facility's CMIs.

07. **Special Rate for Providers that Change Ownership or Close.** When a facility changes ownership or closes, a closing cost report is not required. Special rate payments made in the closing cost reporting period may be reviewed by the Department. Please see conditions outlined in 16.03.10.269 of IDAPA rule, version 10.1.12.