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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 20-0007

This file contains the following documents in the order listed:

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

June 18, 2020

Matt Wimmer, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
P.O. Box 83720
Boise, ID 83720-0009

Re: Idaho 20-0007

Dear Mr. Wimmer:

We have reviewed the proposed amendment to Attachment 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 20-0007. Effective for services on or after March 3, 2020, this amendment updates the reimbursement methodology for Institutions for Mental Disease (IMDs), critical access hospitals (CAHs), in-state, out-of-state, and state-owned hospitals.

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 20-0007 is approved effective March 3, 2020. 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 Thomas Couch at Thomas.couch@cms.hhs.gov.

Sincerely,

[redacted]

Karen Shields
Acting 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 20-0007**

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
03-03-2020

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)(1), 1905(a)(2), 1905(i) and 2110(a) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
SFY2020 Federal savings of ~~$7,373,000~~ $5,153,255
SFY2021 Federal savings of ~~$20,750,000~~ $20,633,532

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pages 2, 5, and 13b
Attachment 4.19-B, page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, pages 2, 5, and 13b
Attachment 4.19-B, page 1

10. SUBJECT OF AMENDMENT: **Amendment to the State Plan to update the reimbursement policy for Institutions for Mental Disease as well as critical access, in-state, out-of-state, and state-owned hospitals. The SPA will align policy language and establish the need for reductions based on general fund needs.**

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:
MATT WIMMER

14. TITLE:
Administrator

15. DATE SUBMITTED: March 23, 2020

16. RETURN TO:
Matt Wimmer, 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:

18. DATE APPROVED: 6/18/20

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
3/3/20

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Karen Shields

22. TITLE:
Acting Group Director

23. REMARKS:
Pen & Ink authorization received from State on 5/12/2020.
State authorized CMS to add submitted date under block 15.
State authorized CMS to revise FFP amounts within block 7.

FORM HCFA-179 (07-92)

- Case-Mix Index. The Case-Mix Index for a hospital is the average weight of values assigned to a range of diagnostic related groups, including but not limited to, those used in the Medicare system or adjoining states and applied to Medicaid discharges included in a hospital's fiscal year end settlement. 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%).

- Reasonable Costs. Except as otherwise provided in section 453, 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.
    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). No more than eighty-seven percent (87%) of cost will be reimbursed to out-of-state hospitals, excluding out-of-state hospital institutions for mental disease (IMD's) which will be reimbursed ninety-five percent (95%) of cost, and no more than one hundred percent (100%) of cost will be reimbursed to state-owned hospitals. Reimbursement to all other in-state hospitals shall be at a rate of no more than ninety one percent (91%) of cost.

- 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.

458. INSTITUTIONS FOR MENTAL DISEASE (IMD). A hospital of seventeen (17) beds or more that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. This definition does not apply to Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IIDs).

01. PRIVATE FREESTANDING MENTAL HEALTH FACILITIES. Services provided by an in-state private, freestanding mental health hospital facility that is an institution for mental disease, as defined in 42 U.S.C. 1396d(i), will be reimbursed for inpatient services at ninety-one percent (91%) of the Medicare rate effective for those dates of service on which the participant was a resident of that facility. As of March 3, 2020, the department shall reimburse out-of-state hospital institutions for mental disease at ninety-five percent (95%) of cost.

459. AUDIT FUNCTION. Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Title XVIII and Title XIX purposes. The Department may elect to perform an audit even though the Medicare Intermediary does not choose to audit the facility.

460. ADEQUACY OF COST INFORMATION. Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to recipients. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of Reasonable Costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another.

Minimum payment to non-institutional providers of services for individuals eligible for Medicare and Medicaid will be as follows: Medicaid will pay the lesser of the Medicaid allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together.

Except as otherwise noted in this section State developed fee schedule rates are the same for both governmental and private providers of the same service (medical services). The fee schedule and any annual/periodic adjustments to the fee schedule are published on the Department of Health and Welfare website:

http://www.healthandwelfare.idaho.gov

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

- **Customary Charges**. Customary Charges reflect the regular rates for outpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services billed to the Title XIX program.

- **Reasonable Costs.** Except as otherwise provided in subsection 453 in Attachment 4.19-A, 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.

    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). No more than eighty-seven percent (87%) of cost will be reimbursed to out-of-state hospitals, and no more than one hundred percent (100%) of cost will be reimbursed to state-owned hospitals. Reimbursement to all other in-state hospitals shall be at a rate of no more than one hundred percent (100%) of cost, or at a rate otherwise provided in Section 56-265, Idaho Code version as March 3, 2020.

Establishment of payment rates for the following types of care are provided under the program:

1. Inpatient Hospital Services: Refer to Attachment 4.19-A.

2. Outpatient Services:

    a. **Outpatient Hospital Services-** must be provided on-site. Covered outpatient services and items will be paid in behalf of Medical Assistance clients at the lesser of customary charges or the reasonable cost of inpatient services and in accordance with the upper payment limits specified in Chapter 42 of the Code of Federal Regulations Section 447.321. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment that would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement.

        i. Payment to hospitals for clinical diagnostic laboratory tests rendered to outpatients and non-patients will be paid at a rate not to exceed Medicare's fee schedule for each of those types of services. Exceptions included in Section 2303(d) of the Deficit Reduction Act will be paid at a rate not to exceed the Department's Medical Assistance Unit, or its successor's, fee schedule.