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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 21-0003

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

January 25, 2023

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

Re: Idaho 21-0003

Dear Ms. Charron:

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) 21-0003. Effective for services on or July 1, 2021, this amendment updates the supplemental payment methodology to hospitals for inpatient and outpatient services. Specifically, these changes will associate supplemental payments with quality of services and participation in the Healthy Connections Value Care (HCVC) program, further linking inpatient and outpatient hospital services to quality and value of patient care.

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 21-0003 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-21-0003**

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

7. FEDERAL BUDGET IMPACT:
FFY2022 $0
FFY2023 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A pages 13-13a1
Attachment 4.19-B pages 41-42

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A pages 13-13a1
Attachment 4.19-B pages 41-42

10. SUBJECT OF AMENDMENT:
Amendment to the State Plan to update the payment methodology for supplemental payments to hospitals based on the difference between Medicaid payments and the upper payment limit, or UPL.

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: 03-19-2021

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: March 19, 2021

18. DATE APPROVED:
January 25, 2023

PLAN APPROVED – ONE COPY ATTACHED

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

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Rory Howe

22. TITLE: Director, Financial Management Group

23. REMARKS:

conditions are met:

a. Total inpatient and outpatient covered charges are more than fifty thousand dollars (S50,000) in the fiscal year; or

b. When less than fifty thousand dollars ($50,000) of the covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department.

02. 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.

03. 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

hospitals not to allow expenditures paid for by the supplemental payments to be included in costs used to set Medicaid hospital payment rates.

The supplemental payments shall not be subject to rules governing payments to hospitals found in IDAPA 16.03.9 (Effective 3 129/12). However, they shall not exceed the Medicaid upper payment limits for non-state government-owned and/or operated hospital payments. The Medicaid upper payment limit analysis will be performed prior to making the supplemental payments.

For state fiscal year 2022, supplemental payments will be distributed based on each qualifying provider's 2020 calendar year Idaho Medicaid inpatient days. Each state fiscal year thereafter shall be determined in the same manner using a rolling yearly schedule.

Except for critical access hospitals (CAHs) and institutions for mental disease (IMDs), distribution of supplemental payments will be based on quality by participating in the Healthy Connections Value Care (HCVC) program network. Those hospitals who choose not to participate in the HCVC program will see a supplemental payment distribution reduction of fifty percent (50%). Any remaining funds resulting from this reduction will be redistributed to HCVC providers who qualify for a supplemental payment based on the HCVC hospital's percentage of Medicaid inpatient hospital days (prior calendar year starting 2020) to total Medicaid inpatient hospital days (prior calendar year starting 2020) made within the HCVC participant group.

02. SUPPLEMENTAL PAYMENTS FOR PRIVATE HOSPITALS.

The supplemental payments made to private hospitals are subject to prior federal approval and a contractual commitment by the hospitals not to allow expenditures paid for by the supplemental payments to be included in costs used to set Medicaid hospital payment rates.

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 private hospitals with emergency departments, and private hospitals that are categorized as "rehabilitation" or "psychiatric" as provided in section II.C. of the most current "Application for Hospital Licenses and Annual Report." by the Bureau of Facility Standards of the Department of Health and Welfare.

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.

The supplemental payments shall not be subject to rules governing payments to hospitals found in IDAPA 16.03.09 (Effective 3/29/72). However, they shall not exceed the Medicaid upper payment limits private hospital payments. The Medicaid upper payment limit analysis will be performed prior to making the supplemental payments.

For state fiscal year 2022, supplemental payments will be distributed based on qualifying provider's 2020 calendar year Idaho Medicaid inpatient days. Each state fiscal year thereafter shall be determined in the same manner using a rolling yearly schedule. Supplemental payments made to the private 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.

Except for critical access hospitals (CAHs) and institutions for mental disease (IMDs), distribution of supplemental payments will be based on quality by participating in the Healthy Connections Value Care (HCVC) program network. Those hospitals who choose not to participate in the HCVC program will see a supplemental payment distribution reduction of fifty percent (50%). Any remaining funds resulting from this reduction will be redistributed to HCVC providers who qualify for a supplemental payment based on the HCVC hospital's percentage of Medicaid inpatient hospital days (prior calendar year starting 2020) to total Medicaid inpatient hospital days (prior calendar year starting 2020) made within the HCVC participant group.

28.

a. OUTPATIENT SUPPLEMENTAL PAYMENTS FOR NON-STATE GOVERNMENT-OWNED HOSPITALS.

Subject to the provisions of this section, eligible providers of Medicaid outpatient hospital services shall receive a supplemental payment. Eligible providers are non-state 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.

Distributed supplemental payments will be made once each State fiscal year and will be calculated based on a previous cost reporting year's Medicaid payment and cost data. The computation of the Medicaid UPL will utilize cost data derived from Worksheet D, Part V, Line 202 of the Medicare Form 2552.

Beginning with State fiscal year 2022, the Medicaid Upper Payment Limit (UPL) will be computed using Medicare cost finding principles based on the latest cost report available at the time of the calculation for each hospital. This information will be inflated, via the Market Basket Index, to the midpoint of the state fiscal year.

Supplemental payments made to the non-state governmental-owned or -operated hospitals that provide outpatient hospital services will be distributed to all hospitals within that group based on a hospital's percentage of Medicaid outpatient hospital payments to total Medicaid outpatient hospital payments made within the group. The State fiscal year 2022 supplemental payments will be distributed based on the outpatient hospital payments to each hospital in calendar year 2020. This data is derived from the State's Medicaid Management Information System (MMIS).

Payments shall not exceed the Medicaid upper limits for non-state government-owned and/or operated hospital payments for the year in which supplemental payments are made. The Medicaid upper payment limit analysis will be performed prior to making the supplemental payments. For each succeeding State fiscal year, the State will utilize the next calendar year's outpatient hospital payment data for each hospital.

Except for critical access hospitals (CAHs) and institutions for mental disease (IMDs), distribution of supplemental payments will be based on quality by participating in the Healthy Connections Value Care (HCVC) program network. Those hospitals who choose not to participate in the HCVC program will see a supplemental payment distribution reduction of fifty percent (50%). Any remaining funds resulting from this reduction will be redistributed to HCVC providers who qualify for a supplemental payment based on the HCVC hospital's percentage of Medicaid outpatient hospital payments (prior calendar year starting 2020) to total Medicaid outpatient hospital payments (prior calendar year starting 2020) made within the HCVC participant group.

b. OUTPATIENT SUPPLEMENTAL PAYMENTS FOR PRIVATE HOSPITALS.

Subject to the provisions of this section, eligible providers of Medicaid outpatient hospital services shall receive a supplemental payment each state fiscal year. Eligible providers are private hospitals with emergency departments, and private hospitals that are categorized as "rehabilitation" or "psychiatric" as provided in section II.C. of the "Application for Hospital Licenses and Annual Report – 2007" by the Bureau of Facility Standards of the Department of Health and Welfare.

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.

Distributed supplemental payments will be made once each State fiscal year and will be calculated based on a previous cost reporting year's Medicaid payment and cost data. The computation of the Medicaid UPL will utilize cost data derived from Worksheet D, Part V, Line 202 of the Medicare Form 2552.

Beginning with State fiscal year 2022, the Medicaid Upper Payment Limit (UPL) will be computed using Medicare cost finding principles based on the latest cost report available at the time of the calculation for each hospital. This information will be inflated, via the Market Basket Index, to the midpoint of the state fiscal year.
Supplemental payments made to private hospitals are governed by Idaho Code 56-1401 passed in the 2008 Legislative session. Supplemental payments made to the private hospitals that provide outpatient hospital services will be distributed to all hospitals within that group based on a hospital's percentage of Medicaid outpatient hospital payments to total Medicaid outpatient hospital payments made within the group. The State fiscal year 2022 supplemental payments will be distributed based on the outpatient hospital payments to each hospital in calendar year 2020. This data is derived from the State's Medicaid Management Information System (MMIS). Payments shall not exceed the Medicaid upper limits for private hospital payments for the year in which supplemental payments are made. The Medicaid upper payment limit analysis will be performed prior to making the supplemental payments. For each succeeding State fiscal year, the State will utilize the next calendar year's outpatient hospital payment data for each hospital.

Except for critical access hospitals (CAHs) and institutions for mental disease (IMDs), distribution of supplemental payments will be based on quality by participating in the Healthy Connections Value Care (HCVC) program network. Those hospitals who choose not to participate in the HCVC program will see a supplemental payment distribution reduction of fifty percent (50%). Any remaining funds resulting from this reduction will be redistributed to HCVC providers who qualify for a supplemental payment based on the HCVC hospital's percentage of Medicaid outpatient hospital payments (prior calendar year starting 2020) to total Medicaid outpatient hospital payments (prior calendar year starting 2020) made within the HCVC participant group.