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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 21-0012

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

December 11, 2023

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

Re: Idaho 21-0012

Dear Juliet Charron,

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan amendment (SPA) submitted under transmittal number (TN) 21-0012. Effective for services on or after July 1, 2021, this amendment implements a new price-based methodology for private nursing facilities and cost-based methodology for state-owned nursing facilities. This methodology will provide care for nursing facilities based on patient needs, ensure quality of care for patients, and accordance with reasonable cost principles.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) and 1903(a) 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 21-0012 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.

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-21-0012**

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) 1902(a) of the Social Security Act

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

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D pages 1-4, 4a, 15, 15a, 15a-1 16, 18, 19, 25

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D pages 1-4, 15, 15a, 16, 18, 19, 25

10. SUBJECT OF AMENDMENT:
Amendment to the State Plan to implement a new price-based methodology for private nursing facilities and cost-based methodology for state-owned nursing facilities.

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:
ELIZABETH KRIETE

14. TITLE:
Acting Administrator

15. DATE SUBMITTED:
09/28/2021

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 28, 2021

18. DATE APPROVED:
December 11, 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:

State authorized pen and ink changes to block 6, 8 and 9.

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 7/1/21) and 16.03.10.235-256 and 259.296 (effective 3/19/07).

• Idaho's methodology is a price-based prospective reimbursement system with an acuity adjustment for direct care costs and a margin payment, capped at an agreed upon maximum for both the direct care and indirect care components. New rates are effective July 1st of each year and rebased annually with quarterly adjustments for case mix.

- The rate methodology will also include a budget adjustment factor (BAF). A total desired budget for nursing facility reimbursement will be established by legislature and will be effective on July 1 of each year. The budget will be compared to the annual expected Medicaid reimbursement rates for the same rate year. A budget adjustment factor will be established to adjust the expected Medicaid reimbursement rates to meet the approved budget. The BAF may be positive or negative and will apply to all nursing facility rates calculated under the established prospective rate system. The BAF will not be applied to the calculated customary charge for each nursing facility and will not apply to any nursing facility that is retrospectively settled.

• 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, 2021 through June 30, 2022. Rates will be calculated using cost reports ended in calendar period 2019 including an inflation factor (IHS Markit (Global Insight), Table 6.7, CMS Nursing Home without Capital Market Basket or its successor) applied from the mid-point of the cost reporting period to the mid-point of the rate period. Inflation, derived from IHS Markit (Global Insight), Table 6.7, CMS Nursing Home without Capital Market Basket or its successor, will be applied to all rate components, with the exception of property costs.

• For the rate years beginning July 1, 2022, and annually thereafter, rates will be calculated using audited cost reports for periods in the calendar year two (2) years prior to each July 1 (July 1, 2022 rates will use cost reports ended in calendar year 2020 and so forth), including inflation (derived from IHS Markit (Global Insight), Table 6.7, CMS Nursing Home without Capital Market Basket or its successor) adjustments from the mid-point of the cost report period to the mid-point of the rate period, with the exception of property costs.

02. Data Sources used by the State Medicaid Agency 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.

II. Development of the Rate

01. Applicable Case Mix Index (CMI). The Medicaid CMI used in establishing each facility's rate is calculated based on the most recent assessment for each Medicaid resident in the nursing facility on the first day of the month of the preceding quarter (for example, assessments as of April 1st are used to establish the CMI needed to establish rates for the quarter beginning July 1st). Facility-wide CMI is calculated based on the most recent assessment for all residents in the nursing facility. The CMI is recalculated quarterly and each nursing facility's rate is adjusted accordingly. A facility-wide CMI is also established each year by averaging four (4) calendar quarter CMIs for the cost reporting period from historical data to represent each fiscal quarter in the cost reporting period (e.g., for a provider with a September 30 year-end, the cost report year average will use the assessments from Jan. 1, Apr. 1, Jul. 1, and Oct. 1).

02. Applicable Cost data. The cost data used in establishing the cost components of the rate calculation are from the audited cost report which ended during the calendar year two (2) years prior to each July 1 (for example, cost reports ending during the period from January 1, 2019 - December 31, 2019 are used in setting rates effective July 1, 2021). The draft audit of a cost report submitted by a facility will be issued by the State Medicaid Agency no later than five (5) months after the date all information required for completion of the audit is filed with the State Medicaid Agency.

03. Picture Date. A point in time when case mix indexes are calculated for every nursing facility based on the most recent assessment for residents in the nursing facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the nursing facility's rate for the next quarter.

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 price 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 direct care per diem price is calculated by calculating the inflated direct care cost per diem, less food and ancillary costs, from the last audited cost report. Inflation is derived from IHS Markit (Global Insight), Table 6.7, CMS Nursing Home without Capital Market Basket or its successor. The resulting per diem is then divided by the facility wide case mix score related to each provider's cost reporting period to calculate the facility normalized direct cost per diem. The calculated inflated food and ancillary cost, which is not case mix adjusted, is added to the facility normalized direct cost per diem to calculate the total inflated direct cost per diem that is case mix neutral. The calculated direct per diem for all providers is arrayed from low to high, the median bed is calculated and used to identify the median direct care per diem. From there, the bed weighted median direct care cost is identified. This becomes the base for the direct care price. The base of the direct care price is the multiplied by a desired percentage of the median, depending on the facility type (Free-Standing, Behavioral Care Unit – Free-Standing, Hospital-Based, or Behavioral Care Unit – Hospital-Based). The desired percentage of the median for each class were established at the time of the rate system development and will be reviewed for reasonableness, effectiveness, and to ensure the distribution of the number of providers whose direct care cost falls above and below the calculated price is similar to the original model. The following defines the first year (2021) Direct Cost Components:

The direct cost component price calculation is based on a percentage above the median. Freestanding Skilled Nursing Facilities (SNFs), Urban Hospital-Based: Direct: 108.15% above the median. Rural Hospital-Based: Direct: 130.96% above the median. Free-Standing Behavioral Care Unit (BCU) SNFs: 135.59%. At the time these calculations were set, there were no Hospital-Based BCU providers in operation. b. The provider's calculated direct care case mix neutral cost per diem is calculated, as described in 1a. The case mix neutral cost is derived from the facility's calculated direct care cost per day divided by the facility wide case mix index for the cost reporting period.

i. The time period of the cost reporting period used in the direct care calculation is from the last audited cost report from the provider. The audited cost reports for each provider's fiscal year ended 2019 is used for rates effective July 1, 2021 through June 30, 2022. Provider cost reports ended in fiscal period 2020 will be used for rates effective July 1, 2021 through June 30, 2022. This timing will continue into future periods.

ii. The definition of direct care costs remains consistent with the prior rate methodology.

c. Each provider has the opportunity to earn a margin incentive for their direct care costs. The margin incentive will be subject to a cap. The margin cap is calculated by multiplying a margin cap percentage based on the quality payment tier, as determined through the Quality Payment Program, by the price for each facility. The margin cap percentages were established at the time of the rate system development and will be reviewed for reasonableness and effectiveness to ensure the distribution above and below the price are similar to the original model at the same time the quality payment tiers are rebased. The margin cap calculation depends on which quality tier a provider qualifies for. Tier 1 is the highest quality and provides for a higher margin percent, tier 2 is the middle category and will provide for a margin percent between tier 1 and tier 3, and tier 3 is the lowest quality and will provide for the lowest margin percent. The quality tiers are based on the following:

i. The quality payment tier scores use the same measures and tier calculations as the annual nursing facility supplemental payment calculations. The source is based on the calendar year data for the following measures:

a. Eight Minimum Set (MDS) long-stay quality measures. Measures are derived from the Minimum Data Set (MDS) used by CMS in the Five Star quality rating program for nursing facilities.

b. One PointRight Long-Stay Hospitalization measure from the National Quality Forum endorsed measure about hospitalization rates.

c. A Nursing Facility Quality Payment Program (NFQPP) guide explaining the program and its quality measures can be found on the Department of Health and Welfare website at: https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/medicaid-nursing-facilitiesd. If the facility's calculated case mix neutral direct care cost is less than the direct price, a margin component is calculated. The calculated margin for each facility is the lessor of the following:

i. The margin cap calculated in c above; or

ii. The difference between the direct care price for the nursing facility type minus the facility's calculated case mix neutral direct care cost.

e. The direct care component will be established at the lessor of the following:

i. The direct care price for the nursing facility type;

ii. The facility's case mix neutral direct cost plus the margin calculated in d. above.

f. If the direct care price for the nursing facility type is lower, the price, minus the raw food and Medicaid related ancillary portion of the calculated direct care price, is multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period. The raw food and Medicaid related ancillary portion of the price is then added back to arrive at the direct care cost component.

g. If the direct care case mix neutral cost plus margin is lower, these costs, minus raw food and Medicaid related ancillary costs, are 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.

h. The following are direct 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.

i. Direct nursing salaries that include the salaries of licensed registered nurses (RN), certified nurse's aides, and unit clerks;

ii. Routine nursing supplies;

iii. Nursing administration;

iv. Direct portion of Medicaid related ancillary services;

v. Social services;

vi. Raw food;

vii. Employee benefits associated with the direct salaries: and

viii. Medical waste disposal, for rates with effective dates beginning July 1, 2005.

i. The direct price limitation will be calculated by indexing the selected cost data forward by the inflation (derived from IHS Markit (Global Insight), Table 6.7, CMS Nursing Home without Capital Market Basket or its successor) 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 normalized and arrayed from high to low, with all nursing facilities included in the same array, and the bed-weighted median will be computed.

05. **Indirect Care Cost Component.** The indirect care cost component nursing facility's rate is determined as follows: a. The indirect per diem price is applicable to the rate period for a nursing facility type, free-standing and urban hospital-based nursing facilities including behavioral care unit nursing facility providers, or rural hospital-based nursing facilities including behavioral care unit nursing facility providers is identified. The indirect price will be calculated by flating the selected cost data forward by the inflation (derived from IHS Markit (Global Insight), Table 6.7, CMS Nursing Home without Capital Market Basket or its successor) 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. The indirect cost component price calculation is based on a percentage above the median. Freestanding Skilled Nursing Facilities (SNFs), Urban Hospital-Based: Indirect: 103.865% above the median. Rural Hospital-Based: Indirect: 124.101% above the median.

b. The provider's calculated indirect care cost per diem is calculated, as described in 5a. The indirect care cost per diem is derived from the facility's calculated indirect care cost per day for the cost reporting period. Indirect care costs are not case mix adjusted.

i. The time period of the cost reporting period used in the direct care calculation is from the last audited cost report from the provider. The audited cost reports for each provider's fiscal year ended 2019 is used for rates effective July 1, 2021 through June 30, 2022. Provider cost reports ended in fiscal period 2020 will be used for rates effective July 1, 2021 through June 30, 2022. This timing will continue into future periods.

ii. iv. Indirect costs include the costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM and relate to Employee benefits associated with indirect wages, Administration and General care costs, Plant Operations and Maintenance (excluding Utilities), Laundry and Linen, Housekeeping, Non-Food Dietary Costs (non-"raw food" costs), Central Services, Medical Records Activities, and Other costs not included in direct care costs, or costs exempt from cost limits.

c. Each provider has the opportunity to earn a margin incentive for their indirect care costs. The margin incentive will be subject to a cap. The margin cap is calculated by multiplying a margin cap by the price for each facility. The margin cap percentage was set at 5% for all nursing facility types. The margin cap percentages were established at the time of the rate system development and will be reviewed for reasonableness and effectiveness to ensure the distribution above and below the price are similar to the original model at the same time the quality payment tiers are rebased.

i. A program guide explaining the program and its quality measures can be found on the Department of Health and Welfare website at: https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/medicaid-nursing-facilities

d. If the facility's calculated indirect care cost is less than the indirect price, a margin component is calculated. The calculated margin for each facility is the lessor of the following:

i. The margin cap calculated in c above; or

ii. The difference between the indirect care price for the nursing facility type minus the facility's calculated indirect care cost.

iii. The time period of the cost reporting period used in the indirect care calculation is from the last audited cost report from the provider. The audited cost reports for each provider's fiscal year ended 2019 is used for rates effective 7/1/21 – 6/30/22. Provider cost reports ended in fiscal period 2020 will be used for rates effective 7/1/22 – 6/30/23.

e. The indirect care component will be established at the lessor of the following:

i. The indirect price for the nursing facility type;

ii. The facility's indirect cost plus the margin calculated in d. above

f. 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:

i. Activities

ii. Administrative and general care costs

iii. Dietary (non-"raw food" costs)

iv. Employee benefits associated with the indirect salaries

v. Housekeeping

vi. Laundry and linen

vii. Medical records

viii. Other costs not included in direct care costs, or costs exempt from cost limits

ix. Plant operations and maintenance (excluding utilities)

VII. Price Limits Based on Cost Report. Each July 1st price limitations will be established for nursing facilities based on the audited cost reports for the periods ending in the calendar year two (2) years prior to each July 1 (July 1, 2021 price limits will use cost reports ended in calendar year 2019 and so forth), including inflation (derived from IHS Markit (Global Insight), Table 6.7, CMS Nursing Home without Capital Market Basket or its successor) adjustments from the mid-point of the cost report period to the mid-point of the rate period. Calculated limitations will be effective for a one (1) year period, from July 1 through June 30th of each year, which is the rate year.

01. Percentage above Bed-Weighted Median. Prior to establishing the first rates at July 1, 2021, the estimated Medicaid payments under the previous prospective system for the year period from July 1, 2018, through June 30, 2019, were calculated. This amount was 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, were established at a level that approximated the same amount of Medicaid expenditures as would have been produced by the previous prospective system. The percentages were established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the previous prospective system. Once the percentages are established, they 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 were added for free-standing and urban hospital-based behavioral care units and rural hospital-based behavioral care units. The percentages used for each class of nursing facilities was determined and agreed upon during the rate system workgroup meetings. These percentages will be evaluated periodically for reasonableness, effectiveness, and efficiency.

02. Direct Price Limits. The direct price limitation will be calculated by indexing the selected cost data forward by the inflation adjustment (using the Idaho specific inflation index, or if not available, the national 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 Price Limits. The indirect price limitation will be calculated by indexing the selected cost data forward by the inflation adjustment (using the Idaho specific inflation index, or if not available, the national 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. 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 IDAPA 16.03.10 Medicaid Enhanced Plan Benefits 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 IDAPA 16.03.10 Medicaid Enhanced Plan Benefits, 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%). For the rate period effective July 1, 2021, the BCU days as a percentage of total occupied days in the nursing facility must meet or exceed a minimum of twenty five percent (25%). For the rate period effective July 1, 2022 and thereafter, the BCU days as a percentage of total occupied days in the nursing facility must meet or exceed a minimum of thirty percent (30%).

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 State Medicaid Agency 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 State Medicaid Agency. A description of participants is in IDAPA 16.03.10 Medicaid Enhanced Plan Benefits.

ii. The State Medicaid Agency will review this information to determine that the participants meet the requirements of IDAPA 16.03.10 Medicaid Enhanced Plan Benefits 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 IDAPA 16.03.10 Medicaid Enhanced Plan Benefits.

XI. Treatment of New Beds. Facilities that add beds after July I, 1999, will have their reimbursement rate subjected to an additional limitation for the next three (3) years. This limitation will apply beginning with the first rate setting period which utilizes a cost report that includes the date when the beds were added. This provision will be the same for either behavioral care unit facilities or non-behavioral care units.

01. Limitation of Facility's Rate. The facility's rate will be limited to the bed-weighted average of the following two (2) rates:

a. The facility's current prospective rate calculated in accordance with Section II; and

b. The lesser of the following:

i. The current median rate for nursing facilities of that type, free-standing, rural hospital-based, or urban hospital-based, established each July 1st, reduced by 10%; or .

ii. The nursing facility's current prospective rate calculated in accordance with IDAPA 16.03.10 Medicaid Enhanced Plan Benefits, reduced by 10%.

c. For any beds added prior to July 1, 2021, the Limitation of Facility's Rate will be limited to the bed-weighted average of the following two (2) rates:

i. The facility's current prospective rate calculated in accordance with IDAPA 16.03.10 Medicaid Enhanced Plan Benefits; and

ii. The current median rate for nursing facilities of that type, free-standing, rural hospital-based, or urban hospital-based, established each July 1st.

The current median rate for nursing facilities of that type, free-standing, rural hospital-based or urban hospital-based, established each July 1st.

02. Calculation of the Bed-Weighted Average. The current calculated facility rate is multiplied by the number of beds in existence prior to the addition. The median rate is multiplied by the number of added beds, weighted for the number of days in the cost reporting period for which they were in service. These two (2) amounts are added together and divided by the total number of beds, with the new beds being weighted if they were only in service for a portion of the year. The resulting per diem amount represents an overall limitation on the facility's reimbursement rate. Providers with calculated rates that do not exceed the limitation receive their calculated rate.

X. Treatment of New Facilities. Facilities constructed on or after July 1, 2023, will be reimbursed at the median rate for skilled care facilities of that type (freestanding or hospital-based) for the first four (4) full years of operation. During the period of limitation, the facility's rate will be modified each July 1st to reflect the current median rate for skilled care facilities of that type, reduced by 10%. After the first four (4) full years, the facility will have its rate established at the next July 1st with the existing facilities.

01. Grandfather Provision. Any new facilities that were licensed prior to July 1, 2023, will be grandfathered in for rate setting purposes. These facilities will be reimbursed at the median rate for the skilled care facilities of that type (freestanding or hospital-based) for the first four (4) full years of operation. During the period of limitation, the facility's rate will be modified each July 1st to reflect the current median rate for skilled care facilities of that type. For the year four (4) rate only, the median rate for that facility type will be inflated by 4% on the BAF adjusted, non-property rate components. The property rental component of the rate will be replace with the rental rate for a building age of 0, including the BAF adjustment, if necessary. After the first four (4) full years, the facility will have its rate established at the next July 1st with the existing facilities in accordance with IDAPA 16.03.10 Medicaid Enhanced Plan Benefits.

XI. Interim Adjustments to Rates As A Result Of New Mandates. Certain incurred costs, as a result of federal or state legal mandates, are excluded from the cost limit calculations and are subject to retrospective settlement at the discretion of the State Medicaid Agency, and could result in changes to the prospective rates to assure equitable reimbursement. Incurred costs must increase a minimum of fifty cents per patient day in order for the State Medicaid Agency to adjust interim rates.

01. Changes of More Than Fifty Cents Per Patient Day in Costs. Changes of more than fifty cents ($.50) per patient day in costs otherwise subject to the cost limitations incurred by a facility as a result of changes in state or federal laws or rules will be reported separately on the cost report until such time as they can be properly reflected in the cost limits.

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. These costs will be reported separately and will not be reimbursed through the rate setting process until the costs are fully represented in the cost data used to establish the cost limitations and rates.

b. If more than one (1) increase occurs as a result of one (1) or more law or rule changes, 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 State Medicaid Agency states otherwise.

02. Future Treatment of Costs. 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 State Medicaid Agency will, at its option, include all of the previously excluded costs related to those increases in the calculation of costs subject to the cost center limits. The intent of this provision is for costs to be exempt from the cost limits until these costs are able to be fully and equitably incorporated into the data base used to project the cost limits. When cost increases which have been excluded from the cap are incorporated in the inflation (derived from IHS Markit (Global Insight), Table 6.7, CMS Nursing Home without Capital Market Basket or its successor) indices used to set the cost limits, the cost indices will be adjusted to exclude the influence of such changes if the amount included in the index is identified. When the cost limits are set to include previously excluded amounts, any adjustments made to the indices related to the previously excluded costs will be removed.

XII. Minimum Data Set (MDS) Reviews

01. Facility Review. The definition of a Picture Date is a point in time when case mix indexes are calculated for every nursing facility based on the residents in the nursing facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the nursing facility's rate for the next quarter. Subsequent to the picture date each facility will be sent a copy of its resident roster (a listing of residents, their Resource Utilization Group (RUG) (or its successor) classification, case mix index, and identification as Medicaid or other). It will be the facilities responsibility at that time to review the roster for accuracy. If the roster is accurate, the facility will sign and return the roster for rate setting. If any errors are detected, those errors will be communicated to the State Medicaid Agency in writing along with any supporting documentation. If the signed resident roster is not returned and no errors are communicated to the State Medicaid Agency, the original resident roster will be used for rate setting. Once the resident roster has been used for rate setting, it will be considered final unless modified by subsequent State Medicaid Agency review.

02. State Medicaid Agency Review. If a State Medicaid Agency review of the MDS data reveals errors that result in an incorrect case mix index, the provider's rate will be retroactively adjusted, for all quarters containing the incorrect assessment, and an amount due to or from the State Medicaid Agency will be calculated. This does not include residents who received the default classification due to incomplete or inconsistent MDS data.

XV. Recapture of Depreciation. Where depreciable assets that were reimbursed based on cost and were used in the Medicaid Program by a facility subsequent to January 1, 1982, and for which depreciation has been reimbursed by the Program, are sold for an amount in excess of their net book value, depreciation so reimbursed will be recaptured from the buyer of the facility in an amount equal to reimbursed depreciation after January 1, 1982, or gain on the sale, whichever is less.

01. Amount Recaptured. Depreciation will be recaptured in full if a sale of a depreciated facility takes place within the first five (5) years of a seller's ownership. Credit will be given for the period of ownership prior to January 1, 1982. For every year the asset is held beyond the first five (5) years, the total depreciation recaptured will be reduced by ten percent (10%) per year of the total depreciation taken.

02. Time Frame. Depreciation will be recaptured by the Medicaid Program from the buyer of the facility over a period of time not to exceed five (5) years from the date of sale, with not less than one-fifth (115) of the total amount being recaptured for each year after such date.

XVI. Retrospective Settlement. When retrospective settlement is applicable, it is based on allowable reimbursement. The costs will not be subject to the same price and other limits determined for prospective payments. Retrospective settlement will be based on an audit report. The provider's direct care costs will not be adjusted for case mix.

01. Providers Eligible for Retrospective Settlement. Any provider that is owned and operated by a State entity will be subject to retrospective settlement. The determination of the operational status of a facility will be determined by the State.