IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1205

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is October 1, 2012.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

PUBLIC HEARING SCHEDULE: A Public hearing concerning this rulemaking will be held as follows:

Wednesday - October 24, 2012
9:00 a.m. MDT

Medicaid Central Office
Conference Room East
3232 Elder Street
Boise, ID 83705

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The changes to these rules implement new Behavioral Care Units (BCU) in nursing facilities (NFs) and intermediate care facilities for people with intellectual disabilities (ICFs/ID). The BCUs are designed to enhance a nursing facility resident's quality of life, quality of care, and enhance their functional and cognitive status and safety. Other changes in this docket continue reimbursement methodologies and rates based on current cost reporting years.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(a) and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

These rule changes provide for the health and safety of individuals living in NFs and ICFs/ID and confer a benefit by providing quality care and services to participants living in these facilities.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year. N/A

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the Department has held discussions with providers and stakeholders over several years to reflect an agreed upon reimbursement for Behavioral Care Units. This rulemaking addresses the issues from those meetings.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Robert Kellerman at (208) 364-1994.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 24, 2012.

DATED this 5th day of September, 2012.

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THE FOLLOWING IS THE TEMPORARY RULE & PROPOSED TEXT OF DOCKET NO. 16-0310-1205

011. DEFINITIONS: E THROUGH K.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Educational Services. Services which are provided in buildings, rooms or areas designated or used as a school or as educational facilities; which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students; and which are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations; are not related services**;** and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. (3-19-07)

02. Eligibility Rules. IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-19-07)

03. Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (3-19-07)

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. (3-19-07)

b. Serious impairment to bodily functions. (3-19-07)

c. Serious dysfunction of any bodily organ or part. (3-19-07)

04. Enhanced Plan. The medical assistance benefits included under this chapter of rules. (3-19-07)

05. EPSDT. Early and Periodic Screening Diagnosis and Treatment. (3-19-07)

06. Equity. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

07. Facility. Facility refers to a hospital, nursing facility, or an intermediate care facility for persons with intellectual disabilities. (3-19-07)

a. "Free-standing and Urban Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.b. or 011.07.h. of this rule, and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. (10-1-12)T

~~a~~b. "Free-standing Nursing Facility" means a nursing facility that is not owned, managed, or operated by, nor is otherwise a part of a licensed hospital. (3-19-07)

~~b~~c. "Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)" means an entity as defined in Subsection 011.~~29~~30 in this rule. ~~(3-19-07)~~(10-1-12)T

~~c~~d. "Nursing Facility (NF)" means a facility licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare patients. (3-19-07)

e. "Rural Hospital-based Provider" means a hospital-based nursing facility not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (10-1-12)T

f. "Rural Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.e., and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. (10-1-12)T

~~d~~g. Skilled Nursing Facility" means a nursing facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and federally certified as a "Nursing Facility" under Title XVIII. (3-19-07)

~~e~~h. "Urban Hospital-~~B~~based Nursing Facilit~~ies~~y" means a hospital-based nursing facilit~~ies~~y located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. ~~(3-19-07)~~(10-1-12)T

08. Fiscal Intermediary Agency. An entity that provides services that allow the participant receiving personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing, training, and dismissing his personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered. (5-8-09)

09. Fiscal Year. An accounting period that consists of twelve (12) consecutive months. (3-19-07)

10. Forced Sale. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (3-19-07)

11. Funded Depreciation. Amounts deposited or held which represent recognized depreciation. (3-19-07)

12. Generally Accepted Accounting Principles (GAAP). A widely accepted set of rules, conventions, standards, and procedures for reporting financial information as established by the Financial Standards Accounting Board. (3-19-07)

13. Goodwill. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is a nonallowable, nonreimbursable expense. (3-19-07)

14. Healthy Connections. The primary care case management model of managed care under Idaho Medicaid. (3-19-07)

15. Historical Cost. The actual cost incurred in acquiring and preparing an asset for use, including

feasibility studies, architects' fees, and engineering studies. (3-19-07)

16. **ICF/ID Living Unit**. The physical structure that an ICF/ID uses to house patients. (3-19-07)

17. **Improvements**. Improvements to assets which increase their utility or alter their use. (3-19-07)

18. **Indirect Care Costs**. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (3-19-07)

a. Activities; (3-19-07)

b. Administrative and general care costs; (3-19-07)

c. Central service and supplies; (3-19-07)

d. Dietary (non-"raw food" costs); (3-19-07)

e. Employee benefits associated with the indirect salaries; (3-19-07)

f. Housekeeping; (3-19-07)

g. Laundry and linen; (3-19-07)

h. Medical records; (3-19-07)

i. Other costs not included in direct care costs, or costs exempt from cost limits; and (3-19-07)

j. Plant operations and maintenance (excluding utilities). (3-19-07)

19. **Inflation Adjustment**. The cost used in establishing a nursing facility's prospective reimbursement rate is indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. (3-19-07)

20. **Inflation Factor**. For use in establishing nursing facility prospective rates, the inflation factor is the Skilled Nursing Facility Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. The national index is used when there is no state or regional index. (3-19-07)

21. **In-State Care**. Medical services provided within the Idaho border or in counties bordering Idaho are considered to be in-state, excluding long term care. (3-19-07)

22. **Inspection of Care Team (IOCT)**. An interdisciplinary team which provides inspection of care in intermediate care facilities for persons with intellectual disabilities approved by the Department as providers of care for eligible medical assistance participants. Such a team is composed of: (3-19-07)

a. At least one (1) registered nurse; and (3-19-07)

b. One (1) Qualified Intellectual Disabilities Professional (QIDP); and when required, one (1) of the following: (3-19-07)

i. A consultant physician; or (3-19-07)

ii. A consultant social worker; or (3-19-07)

iii. When appropriate, other health and human services personnel responsible to the Department as

employees or consultants. (3-19-07)

23. Instrumental Activities of Daily Living (IADL). Those activities performed in supporting the activities of daily living, including, but not limited, to managing money, preparing meals, shopping, light housekeeping, using the telephone, or getting around in the community. (3-19-07)

24. Interest. The cost incurred for the use of borrowed funds. (3-19-07)

25. Interest on Capital Indebtedness. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are reported under property costs. (3-19-07)

26. Interest on Working Capital. The costs incurred for borrowing funds which will be used for "working capital" purposes. These costs are reported under administrative costs. (3-19-07)

27. Interest Rate Limitation. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/ID facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (+1%) at the date the loan is made. (3-19-07)

28. Interim Reimbursement Rate (IRR). A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (3-19-07)

29. Intermediary. Any organization that administers the Title XIX and Title XXI program; in this case the Department of Health and Welfare. (3-19-07)

30. Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). An entity licensed as an ICF/ID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (3-19-07)

31. Keyman Insurance. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. Premiums related to keyman insurance are not allowable. (3-19-07)

012. DEFINITIONS: L THROUGH O.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Lease. A contract arrangement for use of another's property, usually for a specified time period, in return for period rental payments. (3-19-07)

02. Leasehold Improvements. Additions, adaptations, corrections, etc., made to the physical components of a building or construction by the lessee for his use or benefit. Such additions may revert to the owner. Such costs are usually capitalized and amortized over the life of the lease. (3-19-07)

03. Legal Representative. A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. (3-19-07)

04. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (3-19-07)

05. Licensed Bed Capacity. The number of beds which are approved by the Licensure and Certification Agency for use in rendering patient care. (3-19-07)

06. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (3-19-07)

07. Lower of Cost or Charges. Payment to providers (other than public providers furnishing such

services free of charge or at nominal charges to the public) is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers which furnish services free of charge or at a nominal charge are reimbursed fair compensation; which is the same as reasonable cost. (3-19-07)

08. MAI Appraisal. An appraisal which conforms to the standards, practices, and ethics of the American Institute of Real Estate Appraisers and is performed by a member of the American Institute of Real Estate Appraisers. (3-19-07)

09. Major Movable Equipment. Major movable equipment means such items as beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are: (3-19-07)

a. A relatively fixed location in the building; (3-19-07)

b. Capable of being moved, as distinguished from building equipment; (3-19-07)

c. A unit cost of five thousand dollars ($5000) or more; (3-19-07)

d. Sufficient size and identity to make control feasible by means of identification tags; and (3-19-07)

e. A minimum life of three (3) years. (3-19-07)

10. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-19-07)

11. Medicaid. Idaho's Medical Assistance Program. (3-19-07)

12. Medicaid Related Ancillary Costs. For the purpose of these rules, those services provided in nursing facilities considered to be ancillary by Medicare cost reporting principles. Medicaid related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid residents by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid related ancillaries. (3-19-07)

13. Medical Care Treatment Plan. The problem list, clinical diagnosis, and treatment plan of care administered by or under the direct supervision of a physician. (3-19-07)

14. Medical Necessity (Medically Necessary). A service is medically necessary if: (3-19-07)

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (3-19-07)

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly. (3-19-07)

c. Medical services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (3-19-07)

15. Medical Supplies. Items excluding drugs and biologicals and equipment furnished incident to a physician's professional services commonly furnished in a physician's office or items ordered by a physician for the treatment of a specific medical condition. These items are generally not useful to an individual in the absence of an illness and are consumable, nonreusable, disposable, and generally have no salvage value. Surgical dressings, ace bandages, splints and casts, and other devices used for reduction of fractures or dislocations are considered supplies. (3-19-07)

16. Medicare Savings Program. The program formerly known as “Buy-In Coverage,” where the state pays the premium amount for participants eligible for Medicare Parts A and B of Title XVIII. (3-19-07)

17. **Minimum Data Set (MDS)**. A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The version of the assessment document used for rate setting is version 2.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary. (3-19-07)

18. **Minor Movable Equipment**. Minor movable equipment includes such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, buckets, etc. Oxygen concentrators used in lieu of bottled oxygen may, at the facility's option, be considered minor movable equipment with the cost reported as a medical supply. The general characteristics of this equipment are: (3-19-07)

a. No fixed location and subject to use by various departments of the provider's facility; (3-19-07)

b. Comparatively small in size and unit cost under five thousand dollars ($5000); (3-19-07)

c. Subject to inventory control; (3-19-07)

d. Fairly large quantity in use; and (3-19-07)

e. A useful life of less than three (3) years. (3-19-07)

19. **Necessary**. The purchase of goods or services that is required by law, prudent management, and for normal, efficient and continuing operation of patient related business. (3-19-07)

20. **Negotiated Service Agreement (NSA)**. The plan reached by the resident and his representative, or both, and the facility or certified family home based on the assessment, physician or authorized provider's orders, admissions records, and desires of the resident. The NSA must outline services to be provided and the obligations of the facility or certified family home and the resident. (3-19-07)

21. **Net Book Value**. The historical cost of an asset, less accumulated depreciation. (3-19-07)

22. **New Bed**. Subject to specific exceptions stated in these rules, a bed is considered new if it adds to the number of beds for which a nursing facility is licensed on or after July 1, 1999. (3-19-07)

23. **Nominal Charges**. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the related services. (3-19-07)

24. **Nonambulatory**. Unable to walk without assistance. (3-19-07)

25. **Nonprofit Organization**. An organization whose purpose is to render services without regard to gains. (3-19-07)

26. **Normalized Per Diem Cost**. Refers to direct care costs that have been adjusted based on the nursing facility's case mix index for purposes of making the per diem cost comparable among nursing facilities. Normalized per diem costs are calculated by dividing the nursing facility's direct care per diem costs by its nursing facility-wide case mix index, and multiplying the result by the statewide average case mix index. (3-19-07)

27. **Nurse Practitioner**. A licensed professional nurse (RN) who meets all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-19-07)

28. **Nursing Facility (NF)**. An institution, or distinct part of an institution, which is primarily engaged in providing skilled nursing care and related services for participants. It must be an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. The participant must require medical or nursing care, or rehabilitation services for injuries, disabilities, or illness. (3-19-07)

29. **Nursing Facility Inflation Rate**. See the definition of Inflation Factor in Subsection 011.~~17~~20 of

these rules. ~~(3-19-07)~~(10-1-12)T

30. Ordinary. Ordinary means that the costs incurred are customary for the normal operation of the business. (3-19-07)

31. Out-of-State Care. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

257. NURSING FACILITY: DEVELOPMENT OF THE RATE.
Nursing facility rates are prospective, with new rates effective July 1st of each year, and are recalculated annually with quarterly adjustments for case mix. The rate for a nursing facility is the sum of the cost components described in Subsection 257.04 through 257.08 of this rule. 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. For the rate ~~period~~ year of July 1, 2011, through June 30, 2012, rates will be calculated using audited cost reports ended in calendar year 2010 with no allowance for inflation to the rate ~~period~~ year of July 1, 2011, through June 30, 2012. For the rate years beginning July 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. ~~(3-21-12)~~(10-1-12)T

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 1are 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 (for example, an October 1 CMI would represent the fiscal quarter ended September 30th). (3-19-07)

02. Applicable Cost Data. The cost data used in establishing the cost components of the rate calculation are from the audited or unaudited cost report which ended during the previous calendar year (for example, cost reports ending during the period from January 1, 1998 - December 31, 1998 are used in setting rates effective July 1, 1999). The draft audit of a cost report submitted by a facility will be issued by the Department no later than five (5) months after the date all information required for completion of the audit is filed with the Department. (3-19-07)

03. Interim Rates. Nursing facilities with unaudited cost reports are given an interim rate established by the Department until a rate is calculated based on an audited cost report. When audited data are available, a retroactive adjustment to the payment rate is made through the calculation of the finalized rate. (3-19-07)

04. Direct Care Cost Component. The direct care cost component of a nursing facility's rate is determined as follows: (3-19-07)

a. The direct care per diem cost limit applicable to the rate period for a nursing facility type (free-standing and urban hospital-based nursing facility, ~~or~~ rural hospital-based nursing facility, free-standing and urban hospital-based behavioral care unit, or 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. ~~(3-19-07)~~(10-1-12)T

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. (3-19-07)

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. (3-19-07)

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. (3-19-07)

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 facility providers, or rural hospital-based nursing facilities including behavioral care unit nursing facility providers. ~~(3-19-07)~~(10-1-12)T

06. Costs Exempt From Limitation. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates as defined in Section 264 of these rules. (3-19-07)

07. Property Reimbursement. The property reimbursement component is calculated in accordance with Section 275 and Subsection 240.19 of these rules. (3-19-07)

08. Revenue Offset. Revenues from products or services provided to nonpatients will be offset from the corresponding rate component(s) as described in Section 257 of ~~these~~ this rule~~s~~. ~~(3-19-07)~~(10-1-12)T

258. NURSING FACILITY: 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 with an end date of June 30th of the previous year or before. 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. For the rate ~~period~~ year of July 1, 2011, through June 30, 2012, the direct and indirect cost limits were calculated using the most recent ~~finalized~~ audited cost reports adjusted to the midpoint of the cost reporting year's end in calendar year 2010, to allow for no inflation to the rate year. For rates years beginning July 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. ~~(3-21-12)~~(10-1-12)T

01. Percentage Above Bed-Weighted Median. (10-1-12)T

a. 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 Sections 255 through 257 of these rules. 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. (10-1-12)T

b. 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. (10-1-12)T

c. 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. ~~(3-19-07)~~(10-1-12)T

02. Direct Cost Limits. The direct 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 normalized and arrayed from high to low, with ~~*freestanding and hospital-based*~~ all nursing facilities included in the same array, and the bed-weighted median will be computed. ~~*(3-19-07)*~~(10-1-12)T

03. Indirect Cost Limits. 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*~~ all nursing facilities included in the same array, and the bed-weighted median will be computed. ~~*(3-19-07)*~~(10-1-12)T

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 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. (3-29-10)

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 278 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

~~***266. -- 269. (RESERVED)***~~

266. NUSRING 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. (10-1-12)T

01. Determination. The BCU must have a qualifying program and have been providing care in the BCU to behavior residents as of 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. (10-1-12)T

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. (10-1-12)T

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. (10-1-12)T

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.

(10-1-12)T

a. Days approved for a BCU during the 2011 cost report year must be identified. (10-1-12)T

b. To qualify as a BCU, Medicaid BCU days identified in Subsection 266.04.a. of this rule, are divided by total days in the nursing facility and that calculation must equal or exceed a minimum of fifteen percent (15%). (10-1-12)T

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 of this 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: (10-1-12)T

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%). (10-1-12)T

b. The BCU nursing facility provider must provide a list of all residents they believe were qualified for BCU status for the previous year; (10-1-12)T

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. (10-1-12)T

ii. The Department will review this information to determine that the participants meet the requirements of Subsection 266.06 of this 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. of this rule. (10-1-12)T

06. Participant Characteristics. All participants in a BCU must meet the criteria for nursing facility level of care, and have the following characteristics as provided in the participants' MDS assessment: (10-1-12)T

a. Medically based behavior disorder which causes a significantly diminished capacity for judgment, retention of information, or decision making skills, or medically based mental health disorder of diagnosis and has a high level resource use; and (10-1-12)T

b. Must have a history or demonstrate need for additional resources to provide for disruptive behaviors requiring enhanced resource use from nursing facility staff, evidenced by one (1) or more of the following: (10-1-12)T

i. Wandering behaviors; (10-1-12)T

ii. Verbally abusive behaviors; (10-1-12)T

iii. Physically abusive behaviors; (10-1-12)T

iv. Socially inappropriate or disruptive behaviors, such as verbal or vocal symptoms like disruptive sounds, noises, screaming, physical symptoms like self-abusive acts, public sexual behavior or disrobing in public, smearing or throwing food or bodily wastes, hoarding, rummaging through belongings of other residents; (10-1-12)T

v. Behaviors that resist care; or (10-1-12)T

vi. Does not meet unit discharge criteria outlined in Subsection 266.13 of this rule. (10-1-12)T

c. A behavior baseline profile must be established for each participant; (10-1-12)T

d. A behavior intervention program must be in place for each participant, designed to reduce or control the inappropriate behaviors to enhance the participant's quality of life, functional and cognitive status or

safety. (10-1-12)T

07. BCU Annual Renewal. The facility must request continuation in the BCU program annually. The request must include the following: (10-1-12)T

a. A description of the facility's program that includes the required components in Subsections 266.05 and 266.06 of this rule; and (10-1-12)T

b. A profile of the types of behavior of participants served and any restrictions the facility has adopted. (10-1-12)T

08. Administrative and Staffing Requirements. (10-1-12)T

a. Staffing must be at a level necessary for the facility to be able to provide direct supervision of participants as needed. (10-1-12)T

b. Psychiatrist or physician extender must be available to consult as needed for initial and on-going assessments and for 24/7 emergency services. Consultants must make at least quarterly site visits and be available to participate in Behavior Management Team meetings as needed. (10-1-12)T

c. Licensed Master Social Worker (LMSW), Licensed Professional Counselor (LPC), or Licensed Social Worker (LSW) with behavioral experience must be available to consult as needed, make periodic site visits and to participate in the assessment, behavioral intervention planning, behavioral intervention implementation and Behavior Management Team meetings as needed. (10-1-12)T

09. Behavior Management Team Meetings. Weekly behavior management team meetings must be conducted that include but are not limited to psychiatrist, physician, facility social services staff, behavior program director, director of nursing services, dietary manager, recreational services or activity director, and selected primary care staff. Physicians, psychiatrists, social services consultants and other off-site specialists are included as needed, and may participate in person or by telephone. (10-1-12)T

10. Staff Training. Behavioral training classes for staff that are tailored to the needs of the positions involved, and includes appropriate information on: (10-1-12)T

a. Assessment and prevention; (10-1-12)T

b. Medication and side effects; (10-1-12)T

c. Effects of disease process on mood state; (10-1-12)T

d. Safety techniques; (10-1-12)T

e. Deflecting aggression or target behaviors; (10-1-12)T

f. Comprehensive environmental intervention; (10-1-12)T

g. Stress management; and (10-1-12)T

h. Documentation and charting. (10-1-12)T

11. Yearly Training. Yearly training for behavioral interventions and safety techniques is required for staff. (10-1-12)T

12. Care Planning, Behavioral Management, and Programming. Individualized care plans, based on assessments of cognitive and functional abilities, along with behavior analysis to create a strategy for prevention and intervention that are documented for each participant and include the following: (10-1-12)T

a. Thirty (30) day assessments of progress made by each participant, must be completed, documented, and reviewed by the facility's behavioral management team. (10-1-12)T

b. Comprehensive behavior monitoring techniques that track and trend the intensity and daily occurrence of behaviors, successful interventions, and behavior modification techniques used must be documented for each participant. (10-1-12)T

c. Attempts to involve family and responsible parties with the participant through visits, training, outings, or appropriate communications, must be documented. (10-1-12)T

d. Recreational and activity programming must be targeted to specific needs of each individual participant and the behaviors each participant exhibits must be documented. (10-1-12)T

e. Integration for appropriate social interactions must be used when appropriate for each individual participant. (10-1-12)T

f. Community for transition must be used when appropriate for each individual participant. (10-1-12)T

g. Attempts to meet discharge criteria must be documented for each individual participant when progress shows a decline in the need for special care programming. (10-1-12)T

13. Discharge Criteria. The BCU must maintain and document discharge criteria as follows: (10-1-12)T

a. Document improvement in ability to function that would enable transfer to less-restrictive environment. (10-1-12)T

b. Document lack of benefit from specialized programs offered in BCU. (10-1-12)T

c. Document consistent refusals by participant or responsible party to allow interventions that are determined to be helpful, (10-1-12)T

d. Document acute danger to self or others that cannot be managed by staffing in the BCU. (10-1-12)T

e. Document acute physical illness or complications requiring a higher level of medical care than available in the facility. (10-1-12)T

f. A nursing facility provider that is approved for one-hundred percent (100%) behavioral participants will be exempt for the discharge criteria provided in Subsections 266.13.a. through 266.13.e. of this rule. (10-1-12)T

14. Termination of BCU Status. If a provider opts to leave the BCU program, the Department must be notified so the direct care cap can be adjusted to that of a non-BCU provider, beginning with the next rate year. (10-1-12)T

15. Refusal of Admissions. These rules do not preclude a nursing facility from refusing to admit a participant whose needs cannot be met by the nursing facility. (10-1-12)T

267. NURSING FACILITY: NEW BEHAVIORAL CARE UNIT (BCU).

01. Criteria to Qualify as a New BCU. A nursing facility provider must meet the following criteria to qualify as a new BCU nursing facility provider: (10-1-12)T

a. BCU days from the cost report period, 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%). (10-1-12)T

b. A qualifying cost report must demonstrate that the nursing facility provider has a qualifying program in place with residents. (10-1-12)T

02. First Cost Reporting Year. No BCU eligibility, or increased direct care cost limit will be allowed in the first cost reporting year the BCU program is added. (10-1-12)T

03. Qualifying Report in Tandem with BCU Eligibility. Once a qualifying cost report is submitted for the BCU program, and the nursing facility provider qualifies in tandem with the BCU eligibility criteria, the cost report will be used to set a prospective rate effective the following July 1 rate period with the increased direct care cost limit. (10-1-12)T

268. NURSING FACILITY: EXISTING PROVIDER ELECTS TO ADD BEHAVIORAL CARE UNIT (BCU).
An existing nursing facility provider that elects to add a BCU after July 1, 2011, may be deemed eligible after meeting the following requirements: (10-1-12)T

01. Qualifying Cost Report. A qualifying cost report that demonstrates a qualifying program is in place with residents and meets the criteria in Section 282 of these rules. (10-1-12)T

02. Meet Criteria for BCU. The nursing facility provider must meet the criteria for a BCU described in Section 266 of these rules. (10-1-12)T

03. BCU Payments. No BCU payments or increased direct care cost limits will be allowed in the first cost reporting year the program is added. Once a qualifying cost report is submitted, and the provider qualifies in tandem with the BCU criteria, the cost report will be used to set a prospective rate, effective with the following July 1 rate period with the increased direct care cost limit. (10-1-12)T

269. NURSING FACILITY: NEW OWNER OF AN EXISTING NURSING FACILITY WITH A BEHAVIORAL CARE UNIT (BCU).

01. New Owner Elects to Continue BCU. An existing nursing facility that is considered a BCU will continue to be a BCU, if the new owner elects to continue to provide these services. The new owner will receive a rate calculated according to the current change of ownership rules in Section 261 of these rules. The prior owner's cost report will be used until the new owner has a qualifying cost report. They BCU will continue to qualify for the higher direct care cost limit the previous owner was allowed. (10-1-12)T

02. New Owner Does Not Elect to Continue BCU. If the new owner does not elect to operate the BCU, the prior owner's cost report will be used. The direct care cost limit will be adjusted down to that of the non-BCU nursing facility. (10-1-12)T

270. NURSING FACILITY: SPECIAL RATES.
A special rate consists of a facility's daily reimbursement rate for a patient plus an add-on amount. Section 56-117, Idaho Code, 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 ~~*pursuant to the principles found in Section 56-265, Idaho Code*~~. 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 ~~*of Section 56-265, Idaho Code, and*~~ in these rules. ~~*(3-19-07)*~~(10-1-12)T

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. (3-4-11)

02. Effective Date. Upon approval, a special rate is effective on the date the application was received. (3-4-11)

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. (3-19-07)

04. Limitation. A special rate cannot exceed the provider's charges to other patients for similar services. (3-19-07)

05. Prospective Rate Treatment. Prospective treatment of special rates became effective July 1, 2000. Subsections 270.06 and 270.07 of ~~these~~ this rule~~s~~ provide clarification of how special rates are paid under the prospective payment system. ~~(3-19-07)~~(10-1-12)T

06. Determination of Payment for Qualifying Residents. Special rate add-on amounts are calculated using one (1) of the methods described in Subsections 270.06.a. through 270.06.~~d~~c. of ~~these~~ this rule~~s~~. ~~(3-19-07)~~(10-1-12)T

~~*a. Special Care Units. If a facility operates a special care unit, such as a behavioral unit or a Traumatic Brain Injury (TBI) unit, reimbursement is determined as described in Subsections 270.06.a.i. through 270.06.a.v. of these rules.* (3-19-07)~~

~~*i. If the facility is below the direct care cost limit with special care unit costs included, no special rate is paid for the unit.* (3-19-07)~~

~~*ii. If the facility is over the direct care cost limit with special care unit costs included, a special rate add-on amount will be calculated. The special rate add-on amount for the unit is the lesser of the per diem amount by which direct care costs exceed the limit or a calculated add-on amount. The calculated special rate add-on is derived as follows: each Medicaid resident is assigned a total rate equal to the Medicare rate that would be paid if the resident were Medicare eligible. The resident's acuity adjusted Medicaid rate, based on each resident's individual Medicaid CMI, is subtracted from the Medicare rate. The average difference between the Medicaid and the Medicare rates for all special care unit residents is the calculated special rate add-on amount. The calculated special rate add-on amount is compared to the per diem amount by which the provider exceeds the direct care limit. The lesser of these two amounts is allowed as the special rate add-on amount for the unit.* (3-19-07)~~

~~*iii. New Unit Added After July 1, 2000. The Department must approve special rates for new special care units or increases to the number of licensed beds in an existing special care unit. Since a new unit will not have the cost history of an existing unit, the provider's relationship to the cap will not be considered in qualifying for a special rate. New units approved for special rates will have their special add-on amount calculated as the difference between the applicable Medicare price under PPS, and the acuity adjusted Medicaid rate for all unit residents as explained in Section 311.06.a.iii. of these rules. However, the average of these amounts is not limited to the amount the provider is over the direct care cost limit, as the costs of the unit are not in the rate calculation.* (3-19-07)~~

~~iv~~**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. (3-19-07)

~~*v. Unit Routine Customary Charge. If the cost to operate a special care unit is being included in a facility's rate calculation process, the facility must report its usual and customary charge for a semi-private room in the unit on the quarterly reporting form, in addition to the semi-private daily room rate for the general nursing home population. A weighted average routine customary charge is computed to represent the composite of all Medicaid residents in the facility based on the type of rooms they occupy, including the unit.* (3-19-07)~~

b. Equipment and Non-Therapy Supplies. Equipment and non-therapy supplies not addressed in Section 225 of these rules ~~*or adequately addressed in the current RUG system,*~~ 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. ~~(3-4-11)~~(10-1-12)T

c. Ventilator Dependent Residents and Residents Receiving Tracheostomy Care. ~~*The facility need not exceed the direct care limit to receive a special rate for ventilator care and tracheostomy care.*~~ In the case of residents

who are ventilator-dependent and who receive tracheostomy ~~residents~~ care, ~~a two (2) step approach is taken to establish an add-on amount. The first step is the calculation of a staffing add-on for the cost, if any, of additional direct care staff required to meet the exceptional needs of these residents that is higher than the amount indicated on the resident's most recent Medicaid RUG score. The add-on is calculated following the provisions in Subsection 270.06.d. of this rule, adjusted for the appropriate skill level of care staff. The second step is the calculation of an add-on for equipment and non-therapy supplies following the provision in Subsection 270.06.b. of this rule. The combined amount of these two (2) components is considered the special add-on amount to the facility's rate for approved residents receiving this 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: ~~(3-4-11)~~(10-1-12)T

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 (10-1-12)T

ii. Calculation of an add-on for equipment and non-therapy supplies following the provisions in Subsection 270.06.a. of this rule. (10-1-12)T

~~d. Residents Not Residing in a Special Care Unit Requiring One-to-One Staffing Ratios. Facilities may at times have residents who require unusual levels of staffing, such as one to one staffing ratios to meet the exceptional needs of that resident. If the staffing level is higher than the amount indicated on the resident's most recent Medicaid RUG score, the facility may request a special rate. If the resident qualifies for a special rate for additional direct care staff required to meet the exceptional needs of that resident, an hourly add-on rate is computed for reimbursement of approved one-to-one (1 to 1) hours in excess of the minimum staffing requirements in effect for the period. 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. (3-4-11)~~

07. 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 ~~non-unit~~ special rate costs, an adjustment is made to "offset," or reduce costs by an amount equal to total 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. No related adjustment is made to the facility's CMIs. ~~(3-19-07)~~(10-1-12)T

08. 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. (10-1-12)T

(BREAK IN CONTINUITY OF SECTIONS)

622. ICF/ID: PRINCIPLE PROSPECTIVE RATES.
Providers of ICF/ID facilities will be paid a per diem rate which, with certain exceptions, is not subject to an audit settlement. The per diem rate for a fiscal period will be based on audited historical costs adjusted for inflation. The provider ~~will~~ must report these cost items in accordance with other provisions of this chapter or the applicable provisions of PRM consistent with this chapter. Sections 622 through 628 of these rules provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the payment system for ICF/ID providers. Total payment will include the following components: Property reimbursement, capped costs, exempt costs, and excluded costs. Except as otherwise provided in this section, rates calculated for state fiscal year 2012 (July 1, 2011 through June 30, 2012) will be calculated by using finalized cost reports ended in calendar year 2009 with no cost or cost limit adjustments for inflation to the rate period of July 1, 2011, through June 30, 2012. Rates effective July 1, 2012, and every July 1 thereafter, will be calculated by using audited cost reports ended in the calendar year two (2) years prior to each July 1 (July 1, 2012, rates will use cost reports ended in calendar year 2010 and so forth), with no cost or cost limit adjustments for inflation. ~~(3-21-12)~~(10-1-12)T