



Eric Milstead  
Director

# Legislative Services Office

## Idaho State Legislature

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### MEMORANDUM

**TO:** Senators MARTIN, Souza, Jordan and,  
Representatives WOOD, Wagoner, Chew

**FROM:** Elizabeth Bowen - Principal Legislative Drafting Attorney

**DATE:** January 02, 2019

**SUBJECT:** Temporary Rule

IDAPA 16.03.09 - Medicaid Basic Plan Benefits - Adoption of Pending and Temporary Rule - Docket  
No. 16-0309-1801

We are forwarding this temporary rule to you for your information only. No analysis was done by LSO. This rule is posted on our web site. If you have any questions, please call Elizabeth Bowen at the Legislative Services Office at (208) 334-4834. Thank you.

Attachment: Temporary Rule

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# IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

## 16.03.09 – MEDICAID BASIC PLAN BENEFITS

### DOCKET NO. 16-0309-1801

#### NOTICE OF RULEMAKING – ADOPTION OF PENDING AND TEMPORARY RULE

**EFFECTIVE DATE:** The effective date of the temporary rule is January 1, 2019. The pending rule has been adopted by the agency and is now pending review by the 2019 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

**AUTHORITY:** In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting this rule as a temporary rule. The action is authorized pursuant to Section 56-202(b), Idaho Code.

**DESCRIPTIVE SUMMARY:** The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a concise explanatory statement of the reasons for adopting the pending rule:

These rule changes allow eligible Critical Access Hospitals to designate additional acute care beds as swing beds to provide necessary care for individuals, without having to place them in facilities outside of their community and away from their support system. These rules would only apply to those Critical Access Hospitals, who do not have a skilled nursing facility within 35 miles of their facility, and have been approved by Medicare to offer swing-beds.

In accordance with Section 67-5226, Idaho Code, the full text of the temporary rule is being published in this Bulletin following this notice. There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 3, 2018, Idaho Administrative Bulletin, [Vol. 18-10, pages 175 through 184](#).

**TEMPORARY RULE JUSTIFICATION:** Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule confers a benefit as it would allow participants to stay closer to home, and remain in their communities.

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

The fiscal impact in SFY2020 of allowing Critical Access Hospitals who meet the special requirements to request additional swing-bed days from the Department would be a savings of \$87 per person, per day. The savings to the state general fund would be \$25 per person, per day, and the Federal savings would be \$62 per person, per day. This rule change would only allow those Critical Access Hospitals who do not have nursing facilities in their communities to provide additional hospital swing beds that provide the level of care that individuals need to receive care in their local communities.

**ASSISTANCE ON TECHNICAL QUESTIONS:** For assistance on technical questions concerning this pending rule or temporary rule, contact William Deseron at (208) 364-1967.

Dated this 16th day of November, 2018.

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**DOCKET NO. 16-0309-1801 - ADOPTION OF PENDING AND TEMPORARY RULE**

**No substantive changes have been made to the pending rule.**

**The complete text of the proposed rule was published in the Idaho Administrative Bulletin, Volume 18-10, October 3, 2018, pages 175 through 184.**

**This rule has been adopted as a pending rule by the Agency and is now awaiting review and final approval by the 2019 Idaho State Legislature.**

**Additionally, this rule has been adopted as a temporary rule and is effective January 1, 2019.**

**Pursuant to Section 67-5226, Idaho Code, the full text of the temporary rule is being published in this Bulletin.**

**405. INPATIENT HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.**

Under the Medicaid provisions of the Social Security Act, in reimbursing hospitals, the Department will pay the lesser of customary hospital charges or the reasonable cost of inpatient services in accordance with the procedures detailed under this Section of rule. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment that would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement. (3-30-07)

**01. Exemption of New Hospitals.** A hospital that has operated as the type of facility for which it is certified (or the equivalent thereof) under present and previous ownership for less than three (3) full years will be paid in accordance with the Title XVIII principles of reasonable cost reimbursement, including those provisions applicable to new providers for the carryover and recovery of unreimbursed costs, in accordance with 42 CFR Section 413.64. (3-30-07)

**02. Medicaid Inpatient Operating Cost Limits.** The following describe the determination of inpatient operating cost limits. (3-30-07)

**a.** Medicaid Cost Limits for Dates of Service Prior to a Current Year. The reimbursable reasonable costs for services rendered prior to the beginning of the principal year, but included as prior period claims in a subsequent period's cost report, will be subject to the same operating cost limits as the claims under settlement. (3-30-07)

**b.** Application of the Medicaid Cost Limit. In the determination of a hospital's reasonable costs for inpatient services rendered after the effective date of a principal year, a hospital inflation index, computed for each hospital's fiscal year end, will be applied to the operating costs, excluding capital costs and other allowable costs as defined for the principal year and adjusted on a per diem basis for each subsequent year under the hospital inflation index. (7-1-18)

**i.** Each inpatient routine service cost center, as reported in the finalized principal year end Medicare cost report, will be segregated in the Medicaid cost limit calculation and assigned a share of total Medicaid inpatient ancillary costs. The prorated ancillary costs will be determined by the ratio of each Medicaid routine cost center's reported costs to total Medicaid inpatient routine service costs in the principal year. (3-30-07)

**ii.** Each routine cost center's total Medicaid routine service costs plus the assigned share of Medicaid inpatient ancillary costs of the principal year will be divided by the related Medicaid patient days to identify the total costs per diem in the principal year. (3-30-07)

(1) The related inpatient routine service cost center's per diem capital and graduate medical education costs plus the prorated share of inpatient ancillary capital costs will be subtracted from the per diem amount identified in Subsection 405.02.b.ii. of this rule to identify each inpatient routine service cost center per diem cost limit in the principal year. (3-30-07)

(2) If a provider did not have any Medicaid inpatient utilization or render any Medicaid inpatient services in an individual inpatient routine service cost center in the fiscal year serving as the principal year, the principal year for only those routine cost centers without utilization in the provider's principal year will be appropriately calculated using the information available in the next subsequent year in which Medicaid utilization occurred. (3-30-07)

iii. Each routine cost center's cost per diem for the principal year will be multiplied by the hospital inflation index for each subsequent fiscal year. (7-1-18)

iv. The sum of the per diem cost limits for the Medicaid inpatient routine service cost centers of a hospital during the principal year, as adjusted by the hospital inflation index, will be the Medicaid cost limit for operating costs in the current year. (7-1-18)

(1) At the date of final settlement, reimbursement of the Medicaid current year inpatient routine cost centers plus the assigned ancillary costs will be limited to the total per diem operating costs as adjusted for each subsequent fiscal year after the principal year through the current year by the hospital inflation cost index. (7-1-18)

(2) Providers will be notified of the estimated inflation index periodically or hospital inflation index (CMS Market Basket Index) prior to final settlement only upon written request. (7-1-18)

**03. Adjustments to the Medicaid Cost Limit.** A hospital's request for review by the Department concerning an adjustment to or exemption from the cost limits imposed under the provisions set forth in Section 405 of this chapter of rules, must be granted under the following circumstances: (3-30-07)

**a.** Adjustments. Because of Extraordinary Circumstances. Where a provider's costs exceed the Medicaid limit due to extraordinary circumstances beyond the control of the provider, the provider can request an adjustment to the cost limit to the extent the provider proves such higher costs result from the extraordinary circumstances including, but not limited to, increased costs attributable to strikes, fires, earthquake, flood, or similar, unusual occurrences with substantial cost effects. (3-30-07)

**b.** Reimbursement to Public Hospitals. A public hospital that provides services free or at a nominal charge, which is less than, or equal to fifty percent (50%) of its total allowable costs, will be reimbursed at the same rate that would be used if the hospital's charges were equal to, or greater than, its costs. (7-1-18)

**c.** Adjustment to Cost Limits. A hospital is entitled to a reasonable increase in its Medicaid cost limits if the hospital shows that its per diem costs of providing services have increased due to increases in case-mix, the adoption of new or changed services, the discontinuation of services or decrease in average length of stay for Medicaid inpatients since the principal year. Any hospital making such showing is entitled to an increase commensurate with the increase in per diem costs. (7-1-18)

i. The Medicaid operating cost limit may be adjusted by multiplying cost limit by the ratio of the current year's case-mix index divided by the principal year's case-mix index. (7-1-18)

ii. The contested case procedure set forth in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," is available to larger hospitals seeking such adjustments to their Medicaid cost limits. (7-1-18)

**d.** Adjustment to the Proration of Ancillary Costs in the principal year. Where the provider asserts that the proration of ancillary costs does not adequately reflect the total Medicaid cost per diem calculated for the inpatient routine service cost centers in the principal year, the provider may submit a detailed analysis of ancillary services provided to each participant for each type of patient day during each participant's stay during the principal

year. The provider will be granted this adjustment only once upon appeal for the first cost reporting year that the limits are in effect. (3-30-07)

**04. Payment Procedures.** The following procedures are applicable to in-patient hospitals: (3-30-07)

**a.** The participant's admission and length of stay is subject to prior authorization, concurrent review, continued stay review, and retrospective review by a Quality Improvement Organization (QIO) designated by the Department. QIO review will be governed by provisions of the QIO Idaho Medicaid Provider Manual as amended. If a review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. Failure to obtain a timely QIO review as required by Section 402 of this chapter of rules, and as outlined in the QIO Idaho Medicaid Provider Manual as amended, will result in the QIO conducting a late review. After a QIO review has determined that the hospital stay was medically necessary, Medicaid will assess a late review penalty to the hospital as outlined in Section 405 of this rule. (7-1-18)

**i.** All admissions are subject to QIO review to determine if continued stay in inpatient status is medically necessary. A QIO continued stay review is required when the participant's length of stay exceeds the number of days certified by the QIO. If no initial length of stay certification was issued by the QIO, a QIO continued stay review is required when the admission exceeds a number of days as specified by the Department. (3-30-07)

**ii.** Reimbursement for services originally identified as not medically necessary by the QIO will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-30-07)

**iii.** Absent the Medicaid participant's informed decision to incur services deemed unnecessary by the QIO, or not authorized by the QIO due to the negligence of the provider, no payment for denied services may be obtained from the participant. (3-30-07)

**b.** In reimbursing licensed hospitals, the Department will pay the lesser of customary hospital charges or the reasonable cost of semi-private rates for in-patient hospital care as set forth in this rule, unless an exception applies as stated in Section 402 of these rules. The upper limits for payment must not exceed the payment which would be determined as reasonable cost using the Title XVIII standards and principles. (3-30-07)

**05. Hospital Penalty Schedule.** (3-30-07)

**a.** A request for a preadmission and/or continued stay QIO review that is one (1) day late will result in a penalty of two hundred and sixty dollars (\$260), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

**b.** A request for a preadmission and/or continued stay QIO review that is two (2) days late will result in a penalty of five hundred and twenty dollars (\$520), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

**c.** A request for a preadmission and/or continued stay QIO review that is three (3) days late will result in a penalty of seven hundred and eighty dollars (\$780), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

**d.** A request for a preadmission and/or continued stay QIO review that is four (4) days late will result in a penalty of one thousand and forty dollars (\$1,040), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

**e.** A request for a preadmission and/or continued stay QIO review that is five (5) days late or greater will result in a penalty of one thousand three hundred dollars (\$1,300), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

**06. AND Reimbursement Rate.** Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho nursing facilities for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. ICF/ID rates are excluded from this calculation. (3-30-07)

a. The AND reimbursement rate will be calculated by the Department by March 15 of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year. (3-30-07)

b. Hospitals with an attached nursing facility will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and (3-30-07)

c. The Department will pay the lesser of the established AND rate or a facility's customary hospital charge to private pay patients for an AND. (3-30-07)

**07. Reimbursement for Services.** Routine services as addressed in Subsection 405.08 of this rule include all medical care, supplies, and services which are included in the calculation of nursing facility property and non-property costs as described in these rules. Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (3-30-07)

**08. Hospital Swing-Bed Reimbursement.** The Department will pay for nursing facility care in certain rural hospitals. Following approval by the Department, such hospitals may provide service to participants in licensed hospital (~~“swing-beds”~~) ~~beds~~ who require nursing facility level of care. (~~3-30-07~~)(1-1-19)T

a. Facility Requirements. The Department will approve hospitals for nursing facility care provided to eligible participants under the following conditions: (3-30-07)

i. The Department’s Licensure and Certification Section finds the hospital in conformance with the requirements of 42 CFR 482.58 “Special Requirements” for hospital providers of long-term care services (“swing-beds”), or 42 CFR 485.645 – Special requirements for CAH providers of long-term services (“swing-beds”) as applicable; and (~~3-30-07~~)(1-1-19)T

ii. The hospital is approved by the Medicare program for the provision of “swing-bed” services; and (3-30-07)

and iii. The facility does not have a twenty-four (24) hour nursing waiver granted under 42 CFR 488.54(c); (3-30-07)

iv. The hospital must not have had a swing-bed approval terminated within the two (2) years previous to application for swing-bed participation; and (3-30-07)

v. The hospital must be licensed for less than one hundred (100) beds as defined by 42 CFR 482.58(a)(1) for swing-bed purposes; and (3-30-07)

vi. Nursing facility services in swing-beds must be rendered in beds used interchangeably to furnish hospital or nursing facility-type services. (3-30-07)

b. Participant Requirements. The Department will reimburse hospitals for participants under the following conditions: (3-30-07)

i. The participant is determined to be entitled to such services in accordance with IDAPA 16.03.05, “Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled”; and (3-30-07)

ii. The participant is authorized for payment in accordance with IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits,” Subsection 222.02. (3-30-07)

c. Reimbursement for “Swing-Bed” Patient Days. The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: (3-30-07)

i. Payment rates for routine nursing facility services will be at the weighted average Medicaid rate per

patient day paid to hospital-based nursing facility/ICF facilities for routine services furnished during the previous calendar year. ICF/ID facilities' rates are excluded from the calculations. (3-30-07)

ii. The rate will be calculated by the Department by March 15 of each calendar year. The rate will be based on the previous calendar year and effective retroactively for dates of service on or after January 1 of the respective year. (3-30-07)

iii. The weighted average rate for nursing facility swing-bed days will be calculated by dividing total payments for routine services, including patient contribution amounts but excluding miscellaneous financial transactions relating to prior years, by total patient days for each respective level of care occurring in the previous calendar year. (3-30-07)

iv. Routine services include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 225.01. (3-30-07)

v. The Department will pay the lesser of the established rate, the facility's charge, or the facility's charge to private pay patients for "swing-bed" services. (3-30-07)

vi. Reimbursement of ancillary services not included in the nursing facility rates furnished for extended care services will be billed and determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (3-30-07)

vii. The number of swing-bed days that may be reimbursed to a provider in a twelve (12) month period will be limited to the greater of one thousand ninety-five (1,095) days which may be prorated over a shorter fiscal period or, fifteen percent (15%) of the product of the average number of available licensed beds in the hospital in the period and the number of days in the fiscal period. The Department may authorize additional critical access hospital swing-bed days for participants residing in a community without a nursing facility within thirty-five (35) miles contingent on a review of medical necessity, cost-effectiveness, residency, and quality of care. ~~(3-30-07)~~(1-1-19)T

d. Computation of "Swing-Bed" Patient Contribution. The computation of the patient's contribution of swing-bed payment will be in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 224. (3-30-07)

**09. Adjustment for Disproportionate Share Hospitals (DSH).** All Idaho hospitals serving a disproportionate share of low income patients must qualify either as a Mandatory DSH or as Deemed DSH to receive a DSH payment. (3-29-10)

a. DSH Survey Requirements. The Department will send each hospital a DSH survey on or before January 31 of each calendar year. The DSH survey must be returned to the Department on or before May 31 of the same calendar year. A hospital will not receive a DSH payment if the survey is not returned by the deadline, unless good cause is determined by the Department. No later than July 15 of each calendar year, the Department must notify each hospital of their calculated DSH payment and notify each hospital of its preliminary calculated distribution amount. A hospital may file an amended survey to complete, correct, or revise the original DSH survey by submitting the amended survey and supporting documentation to the Department no later than thirty (30) days after the notice of the preliminary DSH calculation is mailed to the hospital. The state's annual DSH allotment payment will be made by September 30 of the same calendar year based on the final DSH surveys and Department data. (3-30-07)

b. Mandatory Eligibility. Mandatory Eligibility for DSH status will be provided for hospitals which: (3-30-07)

i. Meet or exceed the disproportionate share threshold as defined in Subsection 400.13 of these rules. (3-30-07)

ii. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services. (3-29-10)

- (1) Subsection 405.09.b.ii. of this rule does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or (3-30-07)
- (2) Does not offer nonemergency inpatient obstetric services as of December 21, 1987. (3-30-07)
- iii. The MUR will not be less than one percent (1%). (3-30-07)
- iv. If an Idaho hospital exceeds both disproportionate share thresholds, as described in Subsection 400.13 of these rules, and the criteria of Subsections 405.09.b.ii. and 405.09.b.iii. of this rule are met, the payment adjustment will be the greater of the amounts calculated using the methods identified in Subsections 405.09.b.vi. through 405.09.b.x. of this rule. (3-29-10)
- v. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one (1) standard deviation and less than one and one-half (1 1/2) standard deviations above the mean of all Idaho hospitals will receive a DSH payment equal to two percent (2%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)
- vi. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one and one-half (1 1/2) standard deviations and less than two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)
- vii. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates exceeding two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)
- viii. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding twenty-five percent (25%) will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)
- ix. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to, or exceeding, thirty percent (30%) will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)
- c.** Deemed Disproportionate Share Hospital (DSH). All hospitals in Idaho which have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days, and meet the requirements unrelated to patient day utilization specified in Subsection 405.09.b. of this rule, will be designated a Deemed Disproportionate Share Hospital. The disproportionate share payment to a Deemed DSH hospital will be the greater of: (3-29-10)
- i. Five dollars (\$5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or (3-30-07)
- ii. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the DSH allotment amount, less the Mandatory DSH payment amount, divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals. (3-30-07)
- d.** Insufficient DSH Allotment Amounts. When the DSH allotment amount is insufficient to make the aggregate amount of DSH payments to each DSH hospital, payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. (3-30-07)
- e.** DSH Payments Will Not Exceed Costs. A DSH payment will not exceed the costs incurred during the year of furnishing services to individuals who are either eligible for medical assistance under the State Plan or were uninsured for health care services provided during the year. (3-30-07)
- i. Payments made to a hospital for services provided to indigent patients by a state or a unit of local government within a state will not be considered a source of third party payment. (3-30-07)



ii. Claims of uninsured costs which increase the maximum amount which a hospital may receive as a DSH payment must be documented. (3-30-07)

f. DSH Will be Calculated on an Annual Basis. A change in a provider's allowable costs as a result of a reopening or appeal will not result in the recomputation of the provider's annual DSH payment. (3-30-07)

g. To the extent that audit findings demonstrate that DSH payments exceed the documented hospital specific cost limits, the Department will collect overpayments and redistribute DSH payments. (4-7-11)

i. If at any time during an audit the Department discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Department's final audit report regarding that provider, will be referred to the Medicaid Fraud Unit of the Idaho Attorney General's Office. (4-7-11)

ii. The Department will submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with 42 CFR Part 455, Subpart D, "Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments." (4-7-11)

iii. Beginning with FFY 2011, if based on the audit of the DSH allotment distribution, the Department determines that there was an overpayment to a provider, the Department will immediately: (4-7-11)

(1) Recover the overpayment from the provider; and (4-7-11)

(2) Redistribute the amount in overpayment to providers that had not exceeded the hospital-specific upper payment limit during the period in which the DSH payments were determined. The payments will be subject to hospital-specific upper payment limits. (4-7-11)

iv. Disproportionate share payments must not exceed the DSH state allotment, except as otherwise required by the Social Security Act. In no event is the Department obligated to use State Medicaid funds to pay more than the State Medicaid percentage of DSH payments due a provider. (4-7-11)

**10. Out-of-State Hospitals. (3-30-07)**

a. Cost Settlements for Certain Out-of-State Hospitals. Hospitals not located in the state of Idaho will have a cost settlement computed with the state of Idaho if the following conditions are met: (3-30-07)

i. Total inpatient and outpatient covered charges are more than fifty thousand dollars (\$50,000) in the fiscal year; or (3-30-07)

ii. When less than fifty thousand dollars (\$50,000) of covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department. (3-30-07)

b. Payment for Hospitals Without Cost Settlement. Those out-of-state hospitals not cost settling with the state will have annually adjusted rates of payment no greater than seventy-five percent (75%) for inpatient covered charges and no greater than eighty percent (80%) of outpatient covered charges or, the Department's established fee schedule for certain outpatient services. These rates represent average inpatient and outpatient reimbursement rates paid to Idaho hospitals. (3-30-07)

**11. Audit Function.** Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Title XVIII and Medicaid purposes. The Department may elect to perform an audit even though the Medicare Intermediary does not choose to audit the facility. (3-30-07)

**12. Adequacy of Cost Information.** Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to participants. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions,

purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another. (3-30-07)

**13. Availability of Records of Hospital Providers.** A participating hospital provider of services must make available to the Department in the state in which the facility is licensed, the provider's fiscal and other necessary records for the purpose of determining its ongoing record keeping capability and to ascertain information pertinent to the determination of the proper amount of program payments due the provider. (3-30-07)

**14. Interim Cost Settlements.** The Department may initiate or a hospital may request an interim cost settlement based on the Medicare cost report as submitted to the Medicare Intermediary. (3-30-07)

**a. Cost Report Data.** Interim settlement cost report data will be adjusted to reflect Medicaid payments and statistical summary reports sent to providers before the filing deadline. (3-30-07)

**b. Hard Copy of Cost Report.** Hospitals which request to undergo interim cost settlement with Idaho Medicaid must submit a hard copy of the Medicare cost report to the Department upon filing with the Intermediary. (3-30-07)

**c. Limit or Recovery of Payment.** The Department may limit a recovery or payment of an interim settlement amount up to twenty-five percent (25%) of the total settlement amount when the cost report information is in dispute. (3-30-07)

**15. Notice of Program Reimbursement.** Following receipt of the finalized Medicare cost report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider which sets forth the amounts of underpayment or overpayment made to the provider. The notice of the results of the final retroactive adjustment will be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Medicaid program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. Such action of recovery or suspension will continue even after a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments will be made to the settlement amount. (3-30-07)

**a. Timing of Notice.** The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the cost report from the Medicare Intermediary. (3-30-07)

**b. Reopening of Completed Settlements.** A Medicaid completed cost settlement may be reopened by the provider or the state within a three (3) year period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the cost report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement. (3-30-07)

**16. Nonappealable Items.** The formula for the determination of the hospital inflation index, the principles of reimbursement which define allowable cost, non-Medicaid program issues, interim rates which are in compliance with state and federal rules, and the preliminary adjustments prior to final cost settlement determinations as supported by properly completed cost reports and audits must not be accepted as appealable items. (7-1-18)

**17. Interim Reimbursement Rates.** The interim reimbursement rates are reasonable and adequate to meet the necessary costs which must be incurred by economically and efficiently operated providers which provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. (3-30-07)

**a. Annual Adjustments.** Interim rates will be adjusted at least annually based on the best information available to the Department. The interim rate will reflect the Medicaid Inpatient Operating Cost Limits used to set inpatient rates and the Reimbursement Floor Percentage. (3-30-07)

**b.** Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (3-30-07)

**c.** Basis for Adjustments. The Department may make an adjustment based on the Medicare cost report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. If the settlement amount is equal to or greater than ten percent (10%) of the payments received or paid and equal to or greater than one hundred thousand dollars (\$100,000), the interim rate will be adjusted to account for half (½) of the difference. (3-30-07)

**d.** Unadjusted Rate. The Medicaid interim reimbursement rate on file is synonymous with the term unadjusted rate used by other payors. (3-30-07)

**18. Audits.** All financial reports are subject to audit by Departmental representatives in accordance with Section 305 of these rules. (3-30-07)