

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 221

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO MEDICAID; AMENDING SECTION 31-873, IDAHO CODE, TO REMOVE A CODE REFERENCE, TO PROVIDE FOR THE DETERMINATION OF COVERED SERVICES AND TO MAKE A TECHNICAL CORRECTION; REPEALING SECTION 39-5606, IDAHO CODE, RELATING TO PAYMENT TO BE MADE TO A PROVIDER; REPEALING SECTION 56-102, IDAHO CODE, RELATING TO PRINCIPLES OF PROSPECTIVE RATES AND PAYMENT; AMENDING SECTION 56-108, IDAHO CODE, TO REVISE A CODE REFERENCE; REPEALING SECTION 56-113, IDAHO CODE, RELATING TO INTERMEDIATE CARE FACILITIES FOR PEOPLE WITH INTELLECTUAL DISABILITIES; AMENDING SECTION 56-117, IDAHO CODE, TO REVISE CODE REFERENCES; AMENDING SECTION 56-118, IDAHO CODE, TO REMOVE CERTAIN SERVICES FROM REIMBURSEMENT RATE REVIEW AND DETERMINATION, TO REMOVE AN ANNUAL REVIEW REQUIREMENT, TO PROVIDE FOR IMPLEMENTATION OF A CERTAIN METHODOLOGY BY RULE, TO REMOVE CERTAIN MINIMUM METHODOLOGY REQUIREMENTS, TO REMOVE CERTAIN REPORTING REQUIREMENTS AND TO REMOVE REFERENCE TO SUBSEQUENT RULES; REPEALING SECTION 56-136, IDAHO CODE, RELATING TO PHYSICIAN AND DENTIST REIMBURSEMENT; AMENDING SECTION 56-209d, IDAHO CODE, TO REMOVE CERTAIN PROVISIONS DEALING WITH MEDICAL ASSISTANCE PAYMENT INCREASES AND TO MAKE TECHNICAL CORRECTIONS; AMENDING SECTION 56-209g, IDAHO CODE, TO REMOVE AN OBSOLETE EFFECTIVE DATE, TO PROVIDE PAYMENT FOR DRUGS PURSUANT TO CERTAIN CRITERIA, TO PROVIDE FOR METHODOLOGY, TO ESTABLISH THE AVERAGE ACQUISITION COST OF A DRUG AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION 56-255, IDAHO CODE, TO PROVIDE FOR SERVICE REIMBURSEMENT WITHIN THE APPROPRIATIONS PROVIDED BY LAW, TO PROVIDE FOR MENTAL HEALTH SERVICES TO BE DELIVERED BY PROVIDERS THAT MEET CERTAIN STANDARDS, TO REVISE SPECIFIC HEALTH BENEFITS FOR PERSONS WITH DISABILITIES OR SPECIAL HEALTH NEEDS, TO REVISE BENEFITS FOR ALL MEDICAID PARTICIPANTS AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION 56-257, IDAHO CODE, TO PROVIDE FOR COPAYMENTS WITHIN THE LIMITS OF FEDERAL MEDICAID LAW AND REGULATION AND TO REVISE WHAT MAY BE INCLUDED IN COPAYMENTS ESTABLISHED BY THE DEPARTMENT OF HEALTH AND WELFARE; AMENDING CHAPTER 2, TITLE 56, IDAHO CODE, BY THE ADDITION OF NEW SECTIONS 56-260 THROUGH 56-266, IDAHO CODE, TO PROVIDE A SHORT TITLE, TO PROVIDE FOR LEGISLATIVE FINDINGS AND INTENT, TO PROVIDE FOR DEFINITIONS, TO PROVIDE FOR A MEDICAID MANAGED CARE PLAN, TO PROVIDE FOR RULEMAKING AUTHORITY REGARDING SPECIFIED SERVICES, TO PROVIDE FOR PROVIDER PAYMENT AND TO PROVIDE AUTHORIZATION TO OBTAIN FEDERAL APPROVAL; AMENDING SECTION 56-1408, IDAHO CODE, TO REVISE EXEMPTIONS TO THE HOSPITAL ASSESSMENT; AMENDING SECTION 56-1504, IDAHO CODE, TO REVISE A DATE ON WHICH CERTAIN RATES ARE EFFECTIVE, TO PROVIDE A RESTRICTION ON THE USE OF THE NURSING FACILITY ASSESSMENT FUND, TO PROVIDE FOR USE OF THE FUND FOR CERTAIN MATCHING PURPOSES AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION 56-1505, IDAHO CODE, TO REMOVE AN EXCEPTION, TO REVISE THE AGGREGATE AMOUNT OF ASSESSMENTS, THE FREQUENCY OF ASSESSMENTS AND WHEN ASSESSMENTS ARE DUE AND TO MAKE A TECHNICAL CORRECTION; AMENDING SECTION 56-1511, IDAHO CODE, TO RE-

MOVE AN EXCEPTION, TO REVISE THE FREQUENCY OF ASSESSMENTS, TO REVISE A DEFINITION, TO REVISE THE YEAR IN WHICH CERTAIN COST REPORTS SHALL BE APPLIED, TO PROVIDE WHAT INFORMATION IS TO BE USED UNDER CERTAIN CIRCUMSTANCES, TO REVISE THE TIME PERIOD IN WHICH AN ASSESSMENT PAYMENT IS DUE AND TO PROVIDE FOR CONSEQUENCES IF AN ASSESSMENT IS NOT TIMELY PAID; REPEALING SECTIONS 56-1504, 56-1505 AND 56-1511, IDAHO CODE, RELATING TO THE NURSING FACILITY ASSESSMENT FUND, NURSING FACILITY ASSESSMENTS AND ANNUAL NURSING FACILITY ASSESSMENT PAYMENTS; AMENDING CHAPTER 15, TITLE 56, IDAHO CODE, BY THE ADDITION OF NEW SECTIONS 56-1504, 56-1505 AND 56-1511, IDAHO CODE, TO PROVIDE FOR THE NURSING FACILITY ASSESSMENT FUND, NURSING FACILITY ASSESSMENTS AND ANNUAL NURSING FACILITY ASSESSMENT PAYMENTS; AMENDING TITLE 56, IDAHO CODE, BY THE ADDITION OF A NEW CHAPTER 16, TITLE 56, IDAHO CODE, TO PROVIDE FOR A SHORT TITLE AND FOR LEGISLATIVE INTENT, TO DEFINE TERMS, TO PROVIDE FOR THE INTERMEDIATE CARE FACILITY ASSESSMENT FUND, TO PROVIDE FOR INTERMEDIATE CARE FACILITY ASSESSMENTS, TO REQUIRE THE DEPARTMENT OF HEALTH AND WELFARE TO SEEK NECESSARY FEDERAL APPROVAL, TO PROVIDE FOR SEPARATE INTERMEDIATE CARE FACILITY ASSESSMENTS FOR MULTIFACILITY LOCATIONS, TO PROVIDE FOR THE TERMINATION OF INTERMEDIATE CARE FACILITY ASSESSMENTS, TO PROVIDE FOR PENALTIES FOR FAILURE TO PAY THE INTERMEDIATE CARE FACILITY ASSESSMENT, TO PROVIDE FOR ANNUAL INTERMEDIATE CARE FACILITY ADJUSTMENT PAYMENTS AND TO PROVIDE FOR RULEMAKING AUTHORITY; AMENDING SECTION 72-803, IDAHO CODE, TO REVISE A CODE REFERENCE; PROVIDING AN EFFECTIVE DATE AND PROVIDING A SUNSET DATE.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 31-873, Idaho Code, be, and the same is hereby amended to read as follows:

31-873. REIMBURSEMENT FOR CERTAIN MEDICAL ASSISTANCE PAYMENTS. (1) For the purpose of assisting counties with their medical indigency claims, state participation in the ~~federal medical assistance~~ {medicaid} program under title XIX of the social security act, as amended, shall be expanded to match federal funds for coverage of services as ~~defined by section 56-209d, Idaho Code~~ determined by the director of the Idaho department of health and welfare.

(2) Boards of county commissioners shall safeguard all provided information as provided for in section 1902(a) (7) of the social security act, 42 CFR 431.300 through 431.307 and sections 56-221 and 56-222, Idaho Code.

SECTION 2. That Section [39-5606](#), Idaho Code, be, and the same is hereby repealed.

SECTION 3. That Section [56-102](#), Idaho Code, be, and the same is hereby repealed.

SECTION 4. That Section 56-108, Idaho Code, be, and the same is hereby amended to read as follows:

56-108. PROPERTY REIMBURSEMENT -- FACILITIES WILL BE PAID A PROPERTY RENTAL RATE, PROPERTY TAXES AND REASONABLE PROPERTY INSURANCE. The provisions of this section shall not apply to hospital-based facilities which are subject to the provisions of section 56-120, Idaho Code, or to intermediate care facilities for people with intellectual disabilities which are subject to the provisions of section 56-~~113~~²⁶⁵, Idaho Code. The provisions of this section are applicable to all other facilities. The property rental rate includes compensation for major movable equipment but not for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. Prior to final audit, the director shall determine an interim rate that approximates the property rental rate. The property rental rate shall be determined as follows:

(1) Except as determined pursuant to this section:

$$\text{Property rental rate} = (\text{"Property base"}) \times (\text{"Change in building costs"}) \times \frac{(40 - \text{"Age of facility"})}{40}$$

where:

(a) "Property base" = \$9.24 for all facilities.

(b) "Change in building costs" = 1.0 from April 1, 1985, through December 31, 1985. Thereafter "Change in building costs" will be adjusted for each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as of September of the prior year, published by the Marshall Swift Valuation Service. However, for freestanding skilled care facilities "change in building costs" = 1.145 from July 1, 1991, through December 31, 1991. Thereafter, change in building costs for freestanding skilled care facilities will be adjusted each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as of September of the prior year as published by the Marshall Swift Valuation Service or the consumer price index for renter's costs available in September of the prior year, whichever is greater.

(c) "Age of facility" = the director shall determine the effective age, in years, of the facility by subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof shall be assigned an age of more than thirty (30) years. However, beginning July 1, 1991, for freestanding skilled care facilities, "age of facility" will be a revised age which is the lesser of the age established under other provisions of this section or the age which most closely yields the rate allowable to existing facilities as of June 30, 1991, under subsection (1) of this section. This revised age shall not increase over time.

(i) If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the director shall set the effective age at thirty (30) years. Adequate documentation shall include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contracts, and original notes of indebtedness. The director shall compute an

appropriate age for facilities when documentation is provided to reflect expenditures for building expansion or remodeling prior to the effective date of this section. The computation shall decrease the age of a facility by an amount consistent with the expenditure and the square footage impacted and shall be calculated as follows:

1. Determine, according to indexes published by the Marshall Swift Valuation Service, the construction cost per square foot of an average class D convalescent hospital in the western region for the year in which the expansion or renovation was completed.

2. Multiply the total square footage of the building following the expansion or renovation by the cost per square foot to establish the estimated replacement cost of the building at that time.

3. The age of the building at the time of construction shall be multiplied by the quotient of total actual renovation or remodeling costs divided by replacement cost. If this number is equal to or greater than 2.0, the age of the building in years will be reduced by this number, rounded to the nearest whole number. In no case will the age be less than zero (0).

(ii) The director shall adjust the effective age of a facility when major repairs, replacement, remodeling or renovation initiated after April 1, 1985, would result in a change in age of at least one (1) year. Such changes shall not increase the allowable property rental rate by more than three-fourths ($3/4$) of the difference between the adjusted property base determined in subsections (1) (a) and (1) (b) of this section and the rental rate paid to the facility at the time of completion of such changes but before the change component has been added to said rate. The adjusted effective age of the facility will be used in future age determinations, unless modified by provisions of this chapter.

(iii) The director shall allow for future adjustments to the effective age of a facility or its rate to reimburse an appropriate amount for property expenditures resulting from new requirements imposed by state or federal agencies. The director shall, within twelve (12) months of verification of expenditure, reimburse the medicaid share of the entire cost of such new requirements as a one-time payment if the incurred cost for a facility is less than one hundred dollars (\$100) per bed.

(d) At no time shall the property rental rate, established under subsection (1) of this section, be less than that allowed in subsection (1) (c) (ii), with the rate in effect December 31, 1988, being the base. However, subsequent to the application of this paragraph, before any rate increase may be paid, it must first be offset by any rate decrease that would have been realized if the provisions of this paragraph had not been in effect.

(2) A "grandfathered rate" for existing facilities will be determined by dividing the audited allowable annual property costs, exclusive of taxes

1 and insurance, for assets on hand as of January 1, 1985, by the total patient
2 days in the period July 1, 1984, through June 30, 1985. The property rental
3 rate will be the greater of the amount determined pursuant to subsection (1)
4 of this section, or the grandfathered rate. The director shall adjust the
5 grandfathered rate of a facility to compensate the owner for the cost of ma-
6 jor repairs, replacement, expansion, remodeling and renovation initiated
7 prior to April 1, 1985, and completed after January 1, 1985, but completed
8 no later than December 31, 1985. For facilities receiving a grandfathered
9 rate making major repairs, replacement, expansion, remodeling or renova-
10 tion, initiated after January 1, 1986, the director shall compare the grand-
11 fathered rate of the facility to the actual depreciation, amortization, and
12 interest for the current audit period plus the per diem of the recognized
13 cost of major repairs, replacement, expansion, remodeling or renovation,
14 amortized over the American hospital association guideline component useful
15 life. The greater of the two (2) numbers will be allowed as the grandfathered
16 rate. Such changes shall not increase the allowable grandfathered rate by
17 more than three-fourths (3/4) of the difference between the current grandfa-
18 thered rate and the adjusted property base determined in subsections (1) (a)
19 and (1) (b) of this section.

20 (3) The property rental rate per day of care paid to facilities with
21 leases signed prior to March 30, 1981, will be the sum of the annualized al-
22 lowed lease costs and the other annualized property costs for assets on hand
23 as of January 1, 1985, exclusive of taxes and insurance when paid separately,
24 divided by total patient days in the period June 30, 1983, through July 1,
25 1984. Effective July 1, 1989, the director shall adjust the property rental
26 rate of a leased skilled facility under this paragraph to compensate for the
27 cost of major repairs, replacement, expansion, remodeling and renovation
28 initiated after January 1, 1985, by adding the per diem of the recognized
29 cost of such expenditures amortized over the American hospital association
30 guideline component useful life. Such addition shall not increase the al-
31 lowable property rental rate by more than three-fourths (3/4) of the dif-
32 ference between the current property rental rate and the adjusted property
33 base as determined in paragraphs (a) and (b) of subsection (1) of this sec-
34 tion. Where such leases contain provisions that bind the lessee to accept
35 an increased rate, reimbursement shall be at a rate per day of care which re-
36 flects the increase in the lease rate. Where such leases bind the lessee to
37 the lease and allow the rate to be renegotiated, reimbursement shall be at a
38 rate per day of care which reflects an annual increase in the lease rate not
39 to exceed the increase in the consumer price index for renters costs. After
40 the effective date of this subsection, if such a lease is terminated or if the
41 lease allows the lessee the option to terminate other than by purchase of the
42 facility, the property rental rate shall become the amount determined by the
43 formula in subsection (1) of this section as of the date on which the lease is
44 or could be terminated.

45 (4) (a) In the event of a sale, the buyer shall receive the property
46 rental rate as provided in subsection (1) of this section, except un-
47 der the conditions of paragraph (b) of this subsection or except in the
48 event of the first sale for a freestanding skilled care facility receiv-
49 ing a grandfathered rate after June 30, 1991, whereupon the new owner

1 shall receive the same rate that the seller would have received at any
2 given point in time.

3 (b) In the event of a forced sale of a facility where the seller has been
4 receiving a grandfathered rate, the buyer will receive a rate based upon
5 his incurred property costs, exclusive of taxes and insurance, for the
6 twelve (12) months following the sale, divided by the facility's total
7 patient days for that period, or the property rental rate, whichever is
8 higher, but not exceeding the rate that would be due the seller.

9 SECTION 5. That Section 56-113, Idaho Code, be, and the same is hereby
10 repealed.

11 SECTION 6. That Section 56-117, Idaho Code, be, and the same is hereby
12 amended to read as follows:

13 56-117. PAYMENT OF SPECIAL RATES. The director shall have authority to
14 pay facilities at special rates for care given to patients who have long-term
15 care needs not adequately reflected in the rates calculated pursuant to the
16 principles set forth in section 56-~~102265~~, Idaho Code. The payment for such
17 specialized care will be in addition to any payments made in accordance with
18 other provisions of this chapter. The incremental cost to a facility that
19 exceeds the rate for services provided pursuant to the provisions of section
20 56-~~102265~~, Idaho Code, will be excluded from the computation of payments or
21 rates under other provisions of this chapter. Until the facility applies
22 for a special rate, patients with such needs will be included in the compu-
23 tation of the facility's rates following the principles described in section
24 ~~56-102265~~, Idaho Code.

25 SECTION 7. That Section 56-118, Idaho Code, be, and the same is hereby
26 amended to read as follows:

27 56-118. REIMBURSEMENT RATES. (1) The department shall implement a
28 methodology for reviewing and determining reimbursement rates to private
29 businesses providing developmental disability agency services, mental
30 health services, service coordination and case management services, and
31 residential habilitation agency services ~~and affiliated residential habil-~~
32 ~~itation specialized family home services annually by rule.~~

33 (2) In addition to any policy or federal statutory requirements, such
34 methodology shall incorporate, at a minimum, the ~~following~~:

35 ~~(a) The actual cost of providing quality services, including personnel~~
36 ~~and total operating expenses, directly related to providing such ser-~~
37 ~~vices which shall be provided by the private business entities;~~

38 ~~(b) Changes in the expectations placed on private business providers in~~
39 ~~delivering services;~~

40 ~~(c) Inflationary effects on the private business providers' ability to~~
41 ~~deliver the service since the last adjustment to the rate;~~

42 ~~(d) Comparison of rates paid in neighboring states for comparable ser-~~
43 ~~vices;~~

44 ~~(e) Comparison of any rates paid for comparable services in other pub-~~
45 ~~lic or private capacities.~~

~~(3) A report of the results of this analysis and review shall be sent to the director, to the joint finance-appropriations committee and the health and welfare committees of the senate and the house of representatives by November 30 of each year. The department shall include in the report cost saving suggestions that private businesses shall provide. Any changes in reimbursement rates shall include estimated costs of implementation based on the current caseload forecasts and shall be submitted as part of the department's budget request required in section 67-3502, Idaho Code. Reimbursement rates included in appropriation bills enacted by the legislature shall become effective not later than July 1 of each year.~~

~~(4) The results of this annual review and analysis and subsequent rules do not guarantee a change in reimbursement rates, but shall be a fair and equitable process for establishing and reviewing such rates.~~

SECTION 8. That Section 56-136, Idaho Code, be, and the same is hereby repealed.

SECTION 9. That Section 56-209d, Idaho Code, be, and the same is hereby amended to read as follows:

56-209d. MEDICAL ASSISTANCE PROGRAM ~~-- SERVICES TO BE PROVIDED -- EXPERIMENTAL SERVICES OR PROCEDURES EXCLUDED.~~ Notwithstanding any other provision of this chapter, medical assistance shall increase:

~~(1) Payment as determined under rules established by the director from forty (40) days per fiscal year to unlimited days of inpatient hospital care per state fiscal year.~~

~~(2) Payment as determined under rules established by the director from thirty dollars (\$30.00) per month to an unlimited amount of prescribed drugs for each recipient.~~

~~(3) Provision of eligibility for medical assistance for residents of skilled and intermediate care facilities who meet the medical criteria for medical assistance, from those with countable income of two hundred one and two-tenths percent (201.2%) to those with countable income of three hundred percent (300%) of the SSI standard.~~

~~(4) Payment, as authorized by title XIX of the social security act, as amended, and as determined under rules established by the director for:~~

~~(a) Durable medical equipment.~~

~~(b) Soft organ transplants.~~

~~(c) Adult dental services.~~

~~(d) Adult vision services.~~

~~(e) Adult hearing services.~~

~~(f) Prosthetics.~~

~~(g) Assistive and augmentative communication devices.~~

~~(5) Payment for breast and cervical cancer-related treatment services for persons who are eligible for screening for these cancers under the federal centers for disease control and prevention's national breast and cervical cancer early detection program, and are eligible for medical assistance pursuant to the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000" (Pub. L. 106-354).~~

~~(6) The costs of physician, hospital or other services deemed experimental are excluded from coverage. The director may allow coverage of pro-~~

cedures or services deemed investigational if the procedures or services are as cost-effective as traditional, standard treatments.

SECTION 10. That Section 56-209g, Idaho Code, be, and the same is hereby amended to read as follows:

56-209g. PHARMACY REIMBURSEMENT. (1) Medicaid pharmacy reimbursement levels are a combination of the cost of the drug and a dispensing fee which includes such pharmaceutical care services as counseling, obtaining a patient history, documentation, and dispensing. ~~Effective July 1, 1998,~~ ~~p~~Pharmacy reimbursement levels may be adjusted in accordance with rules promulgated by the director through negotiated rulemaking with interested parties including representatives of the pharmacy profession.

(2) The department will pay the lesser of the provider's usual charge to the general public for a drug or the estimated acquisition cost (EAC) plus a dispensing fee.

(a) The EAC is defined by the department as the average acquisition cost (AAC) of the drug, or when no AAC is available, reimbursement will be wholesale acquisition cost (WAC). WAC shall mean the price, paid by a wholesaler for the drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug as published by a recognized compendia of drug pricing on the last day of the calendar quarter that corresponds to the calendar quarter.

(b) The department shall establish pharmacy dispensing fee payments based on the results of surveys of pharmacies and dispensing rates paid to other payers. The dispensing fee structure will be tiered, with the tiers based on the annual medicaid claims volume of the enrolled Idaho retail pharmacy. All other pharmacy dispensing fees will be the lowest dispensing fee for the tiered structure.

(c) At no time shall the medicaid program pay a higher price for a prescription, including the cost of the drug and the dispensing fee, than the lowest private, commercial payment for the same prescription.

(3) The AAC will be established by the department ~~will utilize periodic~~ by state cost or national surveys to obtain the most accurate pharmacy drug acquisition costs in establishing a the pharmacy reimbursement fee schedule for the product. When surveys are requested by the department to ~~p~~Pharmacies participating in the Idaho medicaid program, they are required to participate in these periodic state cost surveys by disclosing the costs of all drugs net of any special discounts or allowances. Participating pharmacies that refuse to respond to the periodic state surveys will be disenrolled as a medicaid provider.

SECTION 11. That Section 56-255, Idaho Code, be, and the same is hereby amended to read as follows:

56-255. MEDICAL ASSISTANCE PROGRAM -- SERVICES TO BE PROVIDED. (1) The department may make payments for the following services furnished by providers to participants who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be reimbursed only when medically necessary within the appropriations provided by law and in accordance with federal law and regulation, Idaho law and de-

partment rule. Notwithstanding any other provision of this chapter, medical assistance includes the following benefits specific to the eligibility categories established in section 56-254(1), (2) and (3), Idaho Code, as well as a list of benefits to which all Idaho medicaid participants are entitled, defined in subsection (5) of this section.

(2) Specific health benefits and limitations for low-income children and working-age adults with no special health needs include:

(a) All services described in subsection (5) of this section;

(b) Early and periodic screening, diagnosis and treatment services for individuals under age twenty-one (21) years, and treatment of conditions found; and

(c) Cost-sharing required of participants. Participants in the low-income children and working-age adult group are subject to the following premium payments, as stated in department rules:

(i) Participants with family incomes equal to or less than one hundred thirty-three percent (133%) of the federal poverty guideline are not required to pay premiums; and

(ii) Participants with family incomes above one hundred thirty-three percent (133%) of the federal poverty guideline will be required to pay premiums in accordance with department rule.

(3) Specific health benefits for persons with disabilities or special health needs include:

(a) All services described in subsection (5) of this section;

(b) Early and periodic screening, diagnosis and treatment services for individuals under age twenty-one (21) years, and treatment of conditions found;

(c) Case management services as defined in accordance with section 1905(a) (19) or section 1915(g) of the social security act; and

(d) Mental health services delivered by providers that meet national accreditation standards, including:

(i) Inpatient psychiatric facility services whether in a hospital, or for persons under age twenty-two (22) years in a freestanding psychiatric facility, as permitted by federal law, in excess of those limits in department rules on inpatient psychiatric facility services provided under subsection (5) of this section;

(ii) Outpatient mental health services in excess of those limits in department rules on outpatient mental health services provided under subsection (5) of this section; and

(iii) Psychosocial rehabilitation for reduction of mental disability for children under the age of eighteen (18) years with a serious emotional disturbance (SED) ~~and for severely and persistently mentally ill adults,~~ Individuals aged eighteen (18) years or older, to age twenty-one (21) years with severe and persistent mental illness shall have access to benefits up to a weekly cap of five (5) hours while adults over the age of twenty-one (21) years with severe and persistent mental illness shall have access to benefits up to a weekly cap of four (4) hours;

(e) Long-term care services, including:

(i) Nursing facility services, other than services in an institution for mental diseases, subject to participant cost-sharing;

(ii) Home-based and community-based services, subject to federal approval, provided to individuals who require nursing facility level of care who, without home-based and community-based services, would require institutionalization. These services will include community supports, including ~~an~~ options for self-determination or family-directed, which will enable individuals to have greater freedom to manage their own care within the determined budget as defined by department rule; and

(iii) Personal care services in a participant's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse;

(f) Services for persons with developmental disabilities, including:

(i) Intermediate care facility services, other than such services in an institution for mental diseases, for persons determined in accordance with section 1902(a) (31) of the social security act to be in need of such care, including such services in a public institution, or distinct part thereof, for persons with intellectual disabilities or persons with related conditions;

(ii) Home-based and community-based services, subject to federal approval, provided to individuals who require an intermediate care facility for people with intellectual disabilities (ICF/ID) level of care who, without home-based and community-based services, would require institutionalization. These services will include community supports, including ~~an~~ options for self-determination or family-directed, which will enable individuals to have greater freedom to manage their own care within the determined budget as defined by department rule. The department shall respond to requests for budget modifications only when health and safety issues are identified and meet the criteria as defined in department rule; and

(iii) ~~Developmental disability services. The for children shall be available based on need through state plan services or waiver services as described in department shall pay for rehabilitative services, including medical or remedial services provided by a facility that has entered into a provider agreement with the department and is certified as a rule. Developmental disability services for adults shall be provided only through the developmental disabilities agency by the department disability home and community-based waiver for individuals age eighteen (18) years and older who would otherwise be institutionalized in an intermediate care facility. The department shall develop a blended rate covering both individual and group developmental therapy services; and~~
(iv) Adults receiving services through the developmental disability waiver shall be transferred to the aged and disabled waiver at age forty-five (45) years and shall no longer participate in active treatment;

(g) Home health services, including:

(i) Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area;

- 1 (ii) Home health aide services provided by a home health agency;
- 2 and
- 3 (iii) Physical therapy, occupational therapy or speech pathology
- 4 and audiology services provided by a home health agency or medical
- 5 rehabilitation facility;
- 6 (h) Hospice care in accordance with section 1905(o) of the social secu-
- 7 rity act;
- 8 (i) Specialized medical equipment and supplies;
- 9 (j) Medicare cost-sharing, including:
 - 10 (i) Medicare cost-sharing for qualified medicare beneficiaries
 - 11 described in section 1905(p) of the social security act;
 - 12 (ii) Medicare part A premiums for qualified disabled and working
 - 13 individuals described in section 1902(a) (10) (E) (ii) of the social
 - 14 security act;
 - 15 (iii) Medicare part B premiums for specified low-income medicare
 - 16 beneficiaries described in section 1902(a) (10) (E) (iii) of the so-
 - 17 cial security act; and
 - 18 (iv) Medicare part B premiums for qualifying individuals de-
 - 19 scribed in section 1902(a) (10) (E) (iv) and subject to section 1933
 - 20 of the social security act; and
- 21 (k) Nonemergency medical transportation.
- 22 (4) Specific health benefits for persons over twenty-one (21) years of
- 23 age who have medicare and medicaid coverage include:
 - 24 (a) All services described in subsection (5) of this section, other
 - 25 than if provided under the federal medicare program;
 - 26 (b) All services described in subsection (3) of this section, other
 - 27 than if provided under the federal medicare program;
 - 28 (c) Other services that supplement medicare coverage; and
 - 29 (d) Nonemergency medical transportation.
- 30 (5) Benefits for all medicaid participants, unless specifically lim-
- 31 ited in subsection (2), (3) or (4) of this section, include the following:
 - 32 (a) Health care coverage including, but not limited to, basic inpatient
 - 33 and outpatient medical services, and including:
 - 34 (i) Physicians' services, whether furnished in the office, the
 - 35 patient's home, a hospital, a nursing facility or elsewhere;
 - 36 (ii) Services provided by a physician or other licensed practi-
 - 37 tioner to prevent disease, disability and other health conditions
 - 38 or their progressions, to prolong life, or to promote physical or
 - 39 mental health; and
 - 40 (iii) Hospital care, including:
 - 41 1. Inpatient hospital services other than those services
 - 42 provided in an institution for mental diseases;
 - 43 2. Outpatient hospital services; and
 - 44 3. Emergency hospital services;
 - 45 (iv) Laboratory and x-ray services;
 - 46 (v) Prescribed drugs;
 - 47 (vi) Family planning services and supplies for individuals of
 - 48 child-bearing age;
 - 49 (vii) Certified pediatric or family nurse practitioners' ser-
 - 50 vices;

- 1 (viii) Emergency medical transportation;
- 2 (ix) Mental health services, including:
 - 3 1. Outpatient mental health services that are appropriate,
 - 4 within limits stated in department rules; and
 - 5 2. Inpatient psychiatric facility services within limits
 - 6 stated in department rules;
- 7 (x) Medical supplies, equipment, and appliances suitable for use
- 8 in the home; and
- 9 (xi) Physical therapy and ~~related services~~ speech therapies com-
- 10 combined to align with the annual medicare caps; and
- 11 (xii) Occupational therapy to align with the annual medicare cap;
- 12 (b) ~~Primary care case management~~ medical homes;
- 13 (c) ~~Dental services, and medical and surgical services furnished by a~~
- 14 ~~dentist in accordance with section 1905(a) (5) (B) of the social security~~
- 15 ~~act. Children shall have access to prevention, diagnosis and treatment~~
- 16 ~~services as defined in federal law. Adult coverage shall be limited to~~
- 17 ~~medically necessary oral surgery and palliative services and associ-~~
- 18 ~~ated diagnostic services. Select covered benefits include: exams, ra-~~
- 19 ~~diographs, periodontal, oral and maxillofacial surgery and adjunctive~~
- 20 ~~general services as defined in department rule. Pregnant women shall~~
- 21 ~~have access to dental services that reflect evidence-based practice;~~
- 22 (d) Medical care and any other type of remedial care recognized under
- 23 Idaho law, furnished by licensed practitioners within the scope of
- 24 their practice as defined by Idaho law, including:
 - 25 (i) Podiatrists' services based on chronic care criteria as de-
 - 26 defined in department rule;
 - 27 (ii) Optometrists' services based on chronic care criteria as de-
 - 28 defined in department rule;
 - 29 (iii) Chiropractors' services shall be limited to six (6) visits
 - 30 per year; and
 - 31 (iv) Other practitioners' services, in accordance with depart-
 - 32 ment rules;
- 33 (e) ~~Services for individuals with speech, hearing and language disor-~~
- 34 ~~ders, provided by or under the supervision of a speech pathologist or~~
- 35 ~~audiologist as defined in department rule;~~
- 36 (f) Eyeglasses prescribed by a physician skilled in diseases of the eye
- 37 or by an optometrist;
- 38 (g) Services provided by essential providers, including:
 - 39 (i) Rural health clinic services and other ambulatory services
 - 40 furnished by a rural health clinic in accordance with section
 - 41 1905(1) (1) of the social security act;
 - 42 (ii) Federally qualified health center (FQHC) services and other
 - 43 ambulatory services that are covered under the plan and furnished
 - 44 by an FQHC in accordance with section 1905(1) (2) of the social se-
 - 45 curity act;
 - 46 (iii) Indian health services;
 - 47 (iv) District health departments; and
 - 48 (v) The family medicine residency of Idaho and the Idaho state
 - 49 university family medicine residency; and

1 ~~(h) Any other medical care and any other type of remedial care recog-~~
 2 ~~nized under state law, specified by the secretary of the federal depart-~~
 3 ~~ment of health and human services; and~~

4 ~~(i) Physician, hospital or other services deemed experimental are ex-~~
 5 ~~cluded from coverage. The director may allow coverage of procedures or~~
 6 ~~services deemed investigational if the procedures or services are as~~
 7 ~~cost-effective as traditional, standard treatments.~~

8 SECTION 12. That Section 56-257, Idaho Code, be, and the same is hereby
 9 amended to read as follows:

10 56-257. COPAYMENTS. (1) Within the limits of federal medicaid law and
 11 regulations, tThe department of health and welfare shall establish enforce-
 12 able cost sharing in order to increase the awareness and responsibility of
 13 medicaid participants for the cost of their health care and to encourage use
 14 of cost-effective care in the most appropriate setting. Copayments estab-
 15 lished by department rule may include, but not be limited to, the following:

16 ~~(a) Inappropriate emergency room utilization. "Inappropriate emer-~~
 17 ~~gency room utilization" means the use of the emergency room for services~~
 18 ~~that are nonemergency and that can be delivered in a regular clinic~~
 19 ~~setting. If a hospital provider determines that it is reasonable that~~
 20 ~~any prudent layperson would have sought emergency treatment in the~~
 21 ~~same circumstances, a copayment will not be applied to such an indi-~~
 22 ~~vidual even if the care rendered is nonemergency Medicaid services~~
 23 including, but not limited to, chiropractic visits, podiatrist visits,
 24 optometrist visits, physical therapy visits, occupational therapy vis-
 25 its, speech therapy visits, outpatient hospital visits and physician
 26 office visits;

27 ~~(b) Inappropriate use of emergency medicaid funded medical transporta-~~
 28 ~~tion. "Inappropriate use of emergency medical transportation" means~~
 29 ~~the use of reimbursed services, including hospital emergency room and~~
 30 ~~emergency medical transportation for conditions that do not meet the~~
 31 ~~criteria for emergency conditions specified in department rule; and~~

32 ~~(c) Missed appointments with health care providers. The department may~~
 33 ~~limit the types of providers for which copayments for missed appoint-~~
 34 ~~ments are applicable. No such provider will be required by the depart-~~
 35 ~~ment to collect copayments as required in this section; and~~

36 ~~(d) Nonpreferred prescription drugs. A nonpreferred drug is a drug for~~
 37 ~~which an alternative therapeutically interchangeable drug in the same~~
 38 ~~pharmacological class is available whose use provides advantages to~~
 39 ~~the medicaid program based on relative safety, effectiveness, clinical~~
 40 ~~outcomes and cost. Pharmacy providers may be required to collect copay-~~
 41 ~~ments at the point of service. Pharmacy providers shall not be required~~
 42 ~~to dispense any prescribed medication unless a medicaid participant~~
 43 ~~provides for any applicable copayment under this paragraph. Copayments~~
 44 ~~shall not constitute a reduction of overall reimbursement to pharma-~~
 45 ~~cists for the dispensing of prescribed medicine~~ Missed appointments
 46 with health care providers when it is the practice of the health care
 47 provider to charge such copayments to all of their patients regardless
 48 of payer.

1 (2) The director may exempt, subject to federal approval, any group of
2 medicaid participants from the cost-sharing provisions in this section.

3 SECTION 13. That Chapter 2, Title 56, Idaho Code, be, and the same is
4 hereby amended by the addition thereto of a NEW SECTION, to be known and des-
5 ignated as Section 56-260, Idaho Code, and to read as follows:

6 56-260. SHORT TITLE. Sections 56-260 through 56-266, Idaho Code,
7 shall be known and may be cited as the "Medicaid Cost Containment and Health
8 Care Improvement Act."

9 SECTION 14. That Chapter 2, Title 56, Idaho Code, be, and the same is
10 hereby amended by the addition thereto of a NEW SECTION, to be known and des-
11 ignated as Section 56-261, Idaho Code, and to read as follows:

12 56-261. LEGISLATIVE FINDINGS AND INTENT. (1) The legislature finds
13 that the current health care delivery system of payment to medicaid health
14 care providers on a fee for service basis does not provide the appropriate
15 incentives and can be improved by incorporating managed care tools, in-
16 cluding capitation and selective contracting, with the objective of moving
17 toward an accountable care system that results in improved health outcomes.

18 (2) The legislature intends that the provisions of sections 56-260
19 through 56-266, Idaho Code, result in the improved health of public as-
20 sistance recipients while, at the same time, increasing the choices and
21 responsibilities of those recipients. The legislature further intends that
22 these sections result in improved business practices of providers.

23 (3) The legislature directs the department to pursue opportunities in
24 the medicaid program that result in safe and appropriate discharge from pub-
25 lic and private institutions including nursing homes, intermediate care fa-
26 cilities and psychiatric facilities into community settings and that such
27 results should be financially sustainable.

28 (4) Price increases should be implemented only through specific appro-
29 priation authority unless the adjustments are specified in federal law.

30 SECTION 15. That Chapter 2, Title 56, Idaho Code, be, and the same is
31 hereby amended by the addition thereto of a NEW SECTION, to be known and des-
32 ignated as Section 56-262, Idaho Code, and to read as follows:

33 56-262. DEFINITIONS. The definitions contained in section 56-252,
34 Idaho Code, shall apply to sections 56-260 through 56-266, Idaho Code.

35 SECTION 16. That Chapter 2, Title 56, Idaho Code, be, and the same is
36 hereby amended by the addition thereto of a NEW SECTION, to be known and des-
37 ignated as Section 56-263, Idaho Code, and to read as follows:

38 56-263. MEDICAID MANAGED CARE PLAN. (1) The department shall present
39 to the legislature on the first day of the second session of the sixty-first
40 Idaho legislature a plan for medicaid managed care with focus on high-cost
41 populations, including:

- 42 (a) Dual eligibles; and
- 43 (b) High-risk pregnancies.

1 (2) The medicaid managed care plan shall include the following ele-
2 ments:

3 (a) Improved coordination of care through primary care medical homes.

4 (b) Approaches that improve coordination and provide case management
5 for high-risk, high-cost disabled adults and children that reduce costs
6 and improve health outcomes, including mandatory enrollment in special
7 needs plans, and that consider other managed care approaches.

8 (c) Managed care contracts to pay for behavioral health benefits as de-
9 scribed in executive order number 2011-01 and in any implementing leg-
10 islation. At a minimum, the system should include independent, stan-
11 dardized, statewide assessment and evidence-based benefits provided by
12 businesses that meet national accreditation standards.

13 (d) The elimination of duplicative practices that result in unneces-
14 sary utilization and costs.

15 (e) Contracts based on gain sharing, risk-sharing or a capitated basis.

16 (f) Medical home development with focus on populations with chronic
17 disease using a tiered case management fee.

18 SECTION 17. That Chapter 2, Title 56, Idaho Code, be, and the same is
19 hereby amended by the addition thereto of a NEW SECTION, to be known and des-
20 ignated as Section 56-264, Idaho Code, and to read as follows:

21 56-264. RULEMAKING AUTHORITY. In addition to the rulemaking authority
22 granted to the department in this chapter and elsewhere in Idaho Code regard-
23 ing the medicaid program and notwithstanding any other Idaho law to the con-
24 trary, the department shall have the authority to promulgate rules regard-
25 ing:

26 (1) Medical services to:

27 (a) Change the primary case management paid to providers to a tiered
28 payment based on the health needs of the populations that are managed. A
29 lower payment is to be made for healthier populations and a higher pay-
30 ment is to be made for individuals with special needs, disabilities or
31 are otherwise at risk. An incentive payment is to be provided to prac-
32 tices that provide extended hours beyond the normal business hours that
33 help reduce unnecessary higher-cost emergency care;

34 (b) Provide that a healthy connections referral is no longer required
35 for urgent care as an alternative to higher cost but unnecessary emer-
36 gency services; and

37 (c) Eliminate payment for collateral contact;

38 (2) Mental health services to:

39 (a) Eliminate administrative requirements for a functional and intake
40 assessment and add a comprehensive diagnostic assessment addendum;

41 (b) Restrict duplicative skill training from being provided by a men-
42 tal health provider when the individual has chosen to receive skill
43 training from a developmental disability provider. The individual may
44 choose to receive skill training from a mental health provider but can
45 not receive skill building simultaneously from two (2) providers;

46 (c) Increase the criteria for accessing the partial care benefit and
47 restrict to those individuals who have a diagnosis of serious and per-
48 sistent mental illness;

49 (d) Eliminate the requirement for new annual plans; and

1 (e) Require a board certified licensed psychiatrist to approve psy-
 2 chosocial rehabilitation services ordered for adults and children,
 3 provided that no such psychiatrist shall make a referral of such adult
 4 or child to himself or any entity in which the psychiatrist holds an eq-
 5 uity interest or has an employment relationship;
 6 (3) In-home care services to:
 7 (a) Eliminate personal care service coordination; and
 8 (b) Restrict duplicative nursing services from a home health agency
 9 when nursing services are being provided through the aged and disabled
 10 waiver;
 11 (4) Vision services to:
 12 (a) Align coverage requirements for contact lenses with commercial in-
 13 surers and other state medicaid programs; and
 14 (b) Limit coverage for adults based on chronic care criteria;
 15 (5) Audiology services to eliminate audiology benefits for adults;
 16 (6) Developmental disability services to:
 17 (a) Eliminate payment for collateral contact;
 18 (b) Eliminate supportive counseling benefit;
 19 (c) Reduce annual assessment hours from twelve (12) to four (4) hours
 20 and exclude psychological and neuropsychological testing services
 21 within these limits;
 22 (d) Reduce plan development payment from twelve (12) to six (6) hours
 23 and reduce requirements related to adult developmental disabilities
 24 plan development;
 25 (e) Restrict duplicative skill training from being provided by a devel-
 26 opmental disabilities provider when an individual has chosen to receive
 27 skill training from his mental health provider;
 28 (f) Implement changes to certified family homes pursuant to chapter 31,
 29 title 39, Idaho Code, to:
 30 (i) Create approval criteria and process for approving new certi-
 31 fied family homes;
 32 (ii) Recertify current certified family homes; and
 33 (iii) Develop applicant and licensing fees to cover certifying and
 34 recertifying costs;
 35 (g) Move individualized adult budgets to a tiered approach as currently
 36 used by the department for children's developmental therapy; and
 37 (7) Institutional care services to discharge individuals from institu-
 38 tional settings where such services are no longer necessary.

39 SECTION 18. That Chapter 2, Title 56, Idaho Code, be, and the same is
 40 hereby amended by the addition thereto of a NEW SECTION, to be known and des-
 41 ignated as Section 56-265, Idaho Code, and to read as follows:

42 56-265. PROVIDER PAYMENT. (1) Where there is an equivalent, the pay-
 43 ment to medicaid providers:
 44 (a) May be up to but shall not exceed one hundred percent (100%) of the
 45 current medicare rate for primary care procedure codes as defined by the
 46 centers for medicare and medicaid services; and
 47 (b) Shall be ninety percent (90%) of the current medicare rate for all
 48 other procedure codes.

1 (2) Where there is no medicare equivalent, the payment rate to medicaid
2 providers shall be prescribed by rule.

3 (3) The department shall, through the annual budget process, include a
4 line item request for adjustments to provider rates. All changes to provider
5 payment rates shall be subject to approval of the legislature by appropria-
6 tion.

7 SECTION 19. That Chapter 2, Title 56, Idaho Code, be, and the same is
8 hereby amended by the addition thereto of a NEW SECTION, to be known and des-
9 ignated as Section 56-266, Idaho Code, and to read as follows:

10 56-266. AUTHORIZATION TO OBTAIN FEDERAL APPROVAL. The department is
11 authorized to obtain federal approval for the requirements set forth in sec-
12 tions 56-260 through 56-266, Idaho Code.

13 SECTION 20. That Section 56-1408, Idaho Code, be, and the same is hereby
14 amended to read as follows:

15 56-1408. EXEMPTIONS. (1) A State hospital that is a governmental en-
16 tity, including a state agency, is south in Blackfoot, Idaho, and state hos-
17 pital north in Orofino, Idaho, and the department of veterans affairs medi-
18 cal center in Boise, Idaho, are exempt from the assessment required by sec-
19 tion 56-1404, Idaho Code, unless the exemption is adjudged to be unconsti-
20 tutional or otherwise invalid, in which case the hospital shall pay such as-
21 essment.

22 (2) A private hospital that does not provide emergency services through
23 an emergency department and is not categorized as "rehabilitation" or "psy-
24 chiatric" as provided in section II.C. of the "application for hospital li-
25 censes and annual report -- 2007" by the bureau of facility standards of the
26 department of health and welfare, is exempt from the assessment required by
27 section 56-1404, Idaho Code.

28 SECTION 21. That Section 56-1504, Idaho Code, be, and the same is hereby
29 amended to read as follows:

30 56-1504. NURSING FACILITY ASSESSMENT FUND. (1) There is hereby cre-
31 ated in the office of the state treasurer a dedicated fund to be known as
32 the nursing facility assessment fund, hereinafter the "fund," to be adminis-
33 tered by the department. The state treasurer shall invest idle moneys in the
34 fund and any interest received on those investments shall be returned to the
35 fund.

36 (2) Moneys in the fund shall consist of:

- 37 (a) All moneys collected or received by the department from nursing fa-
- 38 cility assessments required by this chapter;
- 39 (b) All federal matching funds received by the department as a result
- 40 of expenditures made by the department that are attributable to moneys
- 41 deposited in the fund;
- 42 (c) Any interest or penalties levied in conjunction with the adminis-
- 43 tration of this chapter; and
- 44 (d) Any appropriations, federal funds, donations, gifts or moneys from
- 45 any other sources.

(3) The fund is created for the purpose of receiving moneys in accordance with this section and section 56-1511, Idaho Code. Collected assessment funds shall be used to secure federal matching funds available through the state medicaid plan, which funds shall be used to make medicaid payments for nursing facility services ~~which that~~ equal or exceed the amount of nursing facility medicaid rates, in the aggregate, as calculated in accordance with the approved state medicaid plan in effect on ~~June 30~~ November 15, 2010. The fund shall not be used to replace any moneys appropriated to the Idaho medical assistance program by the legislature. Moneys in ~~t~~The fund shall be used exclusively for the following purposes:

(a) To pay administrative expenses incurred by the department or its agent in performing the activities authorized by this chapter, provided that such expenses shall not exceed a total of one percent (1%) of the aggregate assessment funds collected for the prior fiscal year.

(b) To reimburse the medicaid share of the assessment as a pass-through.

(c) To, at a minimum, make nursing facility adjustment payments that restore any rate reductions, in the aggregate, for the state fiscal years 2010 and 2011.

(d) To increase nursing facility payments to fund covered services to medicaid beneficiaries within medicare upper payment limits, as negotiated with the department.

(e) To repay the federal government any excess payments made to nursing facilities if the state plan, once approved by CMS, is subsequently disapproved for any reason, and after the state has appealed the findings. Nursing facilities shall refund the excess payments in question to the assessment fund. The state, in turn, shall return funds to both the federal government and nursing facility providers in the same proportion as the original financing. Individual nursing facilities shall be reimbursed based on the proportion of the individual nursing facility's assessment to the total assessment paid by nursing facilities. If a nursing facility is unable to refund payments, the state shall develop a payment plan and deduct moneys from future medicaid payments. The state will refund the federal government for the federal share of these overpayments.

(f) To make refunds to nursing facilities pursuant to section 56-1507, Idaho Code.

(g) To provide state matching funds for the department medicaid trustee and benefit expenditures to the extent that a general fund shortfall exists, or as limited by the maximum assessment as set forth in section 56-1505(2), Idaho Code, whichever is less.

SECTION 22. That Section 56-1505, Idaho Code, be, and the same is hereby amended to read as follows:

56-1505. NURSING FACILITY ASSESSMENTS. (1) Nursing facilities shall pay the nursing facility assessment to the fund in accordance with the provisions of this chapter, with the exception of state ~~and county-owned~~ facilities, which are not required to contribute.

(2) The aggregated amount of assessments for all nursing facilities, during a fiscal year, shall be an amount not exceeding ~~two percent (2%)~~ the

1 maximum percentage allowed under federal law of the total aggregate net
 2 patient service revenue of assessed facilities from each provider's prior
 3 fiscal year. The department shall determine the assessment rate prospec-
 4 tively for the applicable fiscal year on a per-resident-day basis, exclusive
 5 of medicare part A resident days. The per-resident-day assessment rate
 6 shall be uniform. The department shall notify nursing facilities of the as-
 7 sessment rate applicable to the fiscal year by August 30 of that fiscal year.

8 (3) The department shall collect, and each nursing facility shall pay,
 9 the nursing facility assessment on ~~a quarterly~~ an annual basis subject to
 10 the terms of this subsection. The nursing facility assessment shall be ~~due~~
 11 ~~quarterly with the initial payment due within sixty (60) days after the state~~
 12 ~~plan has been approved by CMS. Subsequent quarterly payments are due no later~~
 13 ~~than thirty (30) days after the end of the calendar quarter~~ receipt of the de-
 14 partment invoice.

15 (4) Nursing facilities may increase their charges to other payers to
 16 incorporate the assessment but shall not create a separate line item charge
 17 on the bill reflecting the assessment.

18 SECTION 23. That Section 56-1511, Idaho Code, be, and the same is hereby
 19 amended to read as follows:

20 56-1511. ~~QUARTERLY ANNUAL~~ ANNUAL NURSING FACILITY ADJUSTMENT PAYMENTS. (1)
 21 All nursing facilities, with the exception of the state ~~and county-owned~~ fa-
 22 cilities, shall be eligible for ~~quarterly~~ annual nursing facility adjust-
 23 ments.

24 (2) For the purpose of this section, "~~nursing facility~~ medicaid days"
 25 are days of nursing facility services paid for by the Idaho medical assis-
 26 tance program for the applicable state fiscal year.

27 (a) For state fiscal year 2010~~1~~, medicaid days for each provider's cost
 28 report ending in calendar year 2008, shall be utilized to determine the
 29 nursing facility adjustment payment. When there is not a change in own-
 30 ership, adjustment payments for a new provider without a full year 2008
 31 cost report shall be determined using more current medicaid patient day
 32 information obtained from the provider.

33 (b) For state fiscal year 2011~~2~~, medicaid days for each provider's cost
 34 report ending in calendar year 2009, shall be utilized to determine the
 35 nursing facility adjustment payment. When there is not a change in own-
 36 ership, adjustment payments for a new provider without a full year 2009
 37 cost report shall be determined using more current medicaid patient day
 38 information obtained from the provider.

39 (3) Adjustment payments shall be paid on ~~a quarterly~~ an annual basis to
 40 reimburse covered medicaid expenditures in the aggregate within the upper
 41 payment limit.

42 (4) ~~Each quarterly payment shall be made no later than~~ If a provider
 43 does not pay its annual assessment within thirty (30) days after the receipt
 44 of the last quarterly deposit of the nursing facility assessments required
 45 in section 56-1504, Idaho Code department invoice, no further rate adjust-
 46 ment payments shall be made to the provider until the receipt of all assess-
 47 ments in arrears. If a provider pays its annual assessment more than sixty
 48 (60) days after receiving the department invoice, the subsequent adjustment
 49 payment shall be reduced twenty percent (20%).

(5) The provisions of this section shall be null, void and of no force and effect on July 1, 2011~~2~~.

SECTION 24. That Sections [56-1504](#), [56-1505](#) and [56-1511](#), Idaho Code, be, and the same are hereby repealed.

SECTION 25. That Chapter 15, Title 56, Idaho Code, be, and the same is hereby amended by the addition thereto of NEW SECTIONS, to be known and designated as Sections 56-1504, 56-1505 and 56-1511, Idaho Code, and to read as follows:

56-1504. NURSING FACILITY ASSESSMENT FUND. (1) There is hereby created in the office of the state treasurer a dedicated fund to be known as the nursing facility assessment fund, hereinafter the "fund," to be administered by the department. The state treasurer shall invest idle moneys in the fund and any interest received on those investments shall be returned to the fund.

(2) Moneys in the fund shall consist of:

(a) All moneys collected or received by the department from nursing facility assessments required pursuant to this chapter;

(b) All federal matching funds received by the department as a result of expenditures made by the department that are attributable to moneys deposited in the fund;

(c) Any interest or penalties levied in conjunction with the administration of this chapter; and

(d) Any appropriations, federal funds, donations, gifts or moneys from any other sources.

(3) The fund is created for the purpose of receiving moneys in accordance with this section and section 56-1511, Idaho Code. Collected assessment funds shall be used to secure federal matching funds available through the state medicaid plan, which funds shall be used to make medicaid payments for nursing facility services that equal or exceed the amount of nursing facility medicaid rates, in the aggregate, as calculated in accordance with the approved state medicaid plan in effect on June 30, 2009. The fund shall be used exclusively for the following purposes:

(a) To pay administrative expenses incurred by the department or its agent in performing the activities authorized pursuant to this chapter, provided that such expenses shall not exceed a total of one percent (1%) of the aggregate assessment funds collected for the prior fiscal year.

(b) To reimburse the medicaid share of the assessment as a pass-through.

(c) To, at a minimum, make nursing facility adjustment payments that restore any rate reductions, in the aggregate, for the state fiscal years 2010 and 2011.

(d) To increase nursing facility payments to fund covered services to medicaid beneficiaries within medicare upper payment limits, as negotiated with the department.

(e) To repay the federal government any excess payments made to nursing facilities if the state plan, once approved by CMS, is subsequently disapproved for any reason, and after the state has appealed the findings. Nursing facilities shall refund the excess payments in question to the

assessment fund. The state, in turn, shall return funds to both the federal government and nursing facility providers in the same proportion as the original financing. Individual nursing facilities shall be reimbursed based on the proportion of the individual nursing facility's assessment to the total assessment paid by nursing facilities. If a nursing facility is unable to refund payments, the state shall develop a payment plan and deduct moneys from future medicaid payments. The state will refund the federal government for the federal share of these overpayments.

(f) To make refunds to nursing facilities pursuant to section 56-1507, Idaho Code.

56-1505. NURSING FACILITY ASSESSMENTS. (1) Nursing facilities shall pay the nursing facility assessment to the fund in accordance with the provisions of this chapter, with the exception of state and county-owned facilities, which are not required to contribute.

(2) The aggregated amount of assessments for all nursing facilities, during a fiscal year, shall be an amount not exceeding the maximum percentage allowed under federal law of the total aggregate net patient service revenue of assessed facilities from each provider's prior fiscal year. The department shall determine the assessment rate prospectively for the applicable fiscal year on a per-resident-day basis, exclusive of medicare part A resident days. The per-resident-day assessment rate shall be uniform. The department shall notify nursing facilities of the assessment rate applicable to the fiscal year by August 30 of that fiscal year.

(3) The department shall collect, and each nursing facility shall pay, the nursing facility assessment on an annual basis subject to the terms of this subsection. The nursing facility assessment shall be due annually with the initial payment due within sixty (60) days after the state plan has been approved by CMS. Subsequent annual payments are due no later than thirty (30) days after receipt of the department invoice.

(4) Nursing facilities may increase their charges to other payers to incorporate the assessment but shall not create a separate line item charge on the bill reflecting the assessment.

56-1511. ANNUAL NURSING FACILITY ADJUSTMENT PAYMENTS. (1) All nursing facilities, with the exception of the state and county-owned facilities, shall be eligible for annual nursing facility adjustments.

(2) For the purpose of this section, "nursing facility days" are days of nursing facility services paid for by the Idaho medical assistance program for the applicable state fiscal year.

(a) For state fiscal year 2010, medicaid days for each provider's cost report ending in calendar year 2008 shall be utilized to determine the nursing facility adjustment payment.

(b) For state fiscal year 2011, medicaid days for each provider's cost report ending in calendar year 2009 shall be utilized to determine the nursing facility adjustment payment.

(3) Adjustment payments shall be paid on an annual basis to reimburse covered medicaid expenditures in the aggregate within the upper payment limit.

SECTION 26. That Title 56, Idaho Code, be, and the same is hereby
amended by the addition thereto of a NEW CHAPTER, to be known and designated
as Chapter 16, Title 56, Idaho Code, and to read as follows:

9 56-1601. SHORT TITLE -- LEGISLATIVE INTENT. (1) This chapter shall be
10 known and may be cited as the "Idaho Intermediate Care Facility Assessment
11 Act."

12 (2) It is the intent of the legislature to encourage the maximization of
13 financial resources eligible and available for medicaid services by estab-
14 lishing a fund within the Idaho department of health and welfare to receive
15 ICF assessments to be used in securing federal matching funds under feder-
16 ally prescribed programs available through the state medicaid plan.

18 (1) "CMS" means the centers for medicare and medicaid services.
19 (2) "Department" means the Idaho department of health and welfare.
20 (3) "Fiscal year" means the time period from July 1 to June 30.
21 (4) "Fund" means the ICF assessment fund established pursuant to sec-
22 tion 56-1603, Idaho Code.

23 (5) "ICF" means an intermediate care facility for people with intellec-
24 tual disabilities as defined in section 39-1301, Idaho Code, and licensed
25 pursuant to chapter 13, title 39, Idaho Code.

(6) "Net patient service revenue" means gross revenues from services provided to ICF patients, less reductions from gross revenue resulting from an inability to collect payment of charges. Patient service revenue excludes nonpatient care revenues such as beauty and barber, vending income, interest and contributions, revenues from sale of meals and all outpatient revenues. Reductions from gross revenue includes: bad debts; contractual adjustments; uncompensated care; administrative, courtesy and policy discounts and adjustments; and other such revenue deductions.

(7) "Resident day" means a calendar day of care provided to an ICF resident, including the day of admission and excluding the day of discharge, provided that one (1) resident day shall be deemed to exist when admission and discharge occur on the same day.

38 (8) "Upper payment limit" means the limitation established in 42 CFR
39 section 447.272, that disallows federal matching funds when state medicaid
40 agencies pay certain classes of facilities an aggregate amount for services
41 that exceed the amount that is paid for the same services furnished by that
42 class of facilities under medicare payment principles.

56-1603. INTERMEDIATE CARE FACILITY ASSESSMENT FUND. (1) There is
hereby created in the office of the state treasurer a dedicated fund to be
known as the ICF assessment fund to be administered by the department. The

1 state treasurer shall invest idle moneys in the fund, and any interest re-
 2 ceived on those investments shall be returned to the fund.

3 (2) Moneys in the fund shall consist of:

4 (a) All moneys collected or received by the department from ICF assess-
 5 ments required pursuant to this chapter;

6 (b) All federal matching funds received by the department as a result
 7 of expenditures made by the department that are attributable to moneys
 8 deposited in the fund;

9 (c) Any interest or penalties levied in conjunction with the adminis-
 10 tration of this chapter; and

11 (d) Any appropriation or federal funds.

12 (3) The fund is created for the purpose of receiving moneys in accor-
 13 dance with the provisions of this section and section 56-1604, Idaho Code.
 14 The fund shall not be used to replace any moneys appropriated to the Idaho
 15 medical assistance program by the legislature. Moneys in the fund, which
 16 are deemed to be perpetually appropriated, shall be used exclusively for the
 17 following purposes:

18 (a) To pay administrative expenses incurred by the department or its
 19 agent in performing the activities authorized pursuant to this chapter,
 20 provided that such expenses shall not exceed a total of one percent (1%)
 21 of the aggregate assessment funds collected for the prior fiscal year.

22 (b) To reimburse the medicaid share of the assessment as a pass-
 23 through.

24 (c) To secure federal matching funds available through the state med-
 25 icaid plan, which funds shall be used to make medicaid payments for ICF
 26 services that equal or exceed the amount of ICF medicaid rates, in the
 27 aggregate, as calculated in accordance with the approved state medicaid
 28 plan in effect on July 1, 2011.

29 (d) To increase ICF payments to fund covered services to medicaid bene-
 30 ficiaries within medicare upper payment limits.

31 (e) To, at a minimum, make ICF adjustment payments that restore any rate
 32 reductions, in the aggregate, for the state fiscal years 2011 and 2012,
 33 within medicare upper payment limits.

34 (f) To make refunds to ICFs pursuant to section 56-1607, Idaho Code. If
 35 an ICF is unable to refund payments, the state shall develop a payment
 36 plan and deduct moneys from future medicaid payments. The state will
 37 refund the federal government for the federal share of these overpay-
 38 ments.

39 (g) To make transfers to any other fund in the state treasury, provided
 40 such transfers shall not exceed the amount transferred previously from
 41 that other fund into the ICF assessment fund.

42 (h) To provide state matching funds for department medicaid trustee
 43 and benefit expenditures to the extent that a general fund shortfall
 44 exists, or as limited by the maximum assessment as set forth in section
 45 56-1604(2), Idaho Code, whichever is less.

46 56-1604. INTERMEDIATE CARE FACILITY ASSESSMENTS. (1) The ICF shall
 47 pay the ICF assessment to the fund in accordance with the provisions of this
 48 chapter.

(2) The aggregated amount of assessments for all ICFs during a fiscal year shall be an amount not exceeding the maximum percentage allowed under federal law of the total aggregate net patient service revenue of assessed ICFs from each provider's prior fiscal year. The department shall determine the assessment rate prospectively for the applicable fiscal year on a per-resident-day basis. The per-resident-day assessment rate shall be uniform for all ICFs.

(3) The department shall collect, and each ICF shall pay, the ICF assessment on an annual basis subject to the terms of this subsection. The ICF assessment shall be due no later than thirty (30) days after the receipt of the department invoice.

56-1605. APPROVAL OF STATE PLAN. The department shall seek necessary federal approval in the form of the state plan amendments in order to implement the provisions of this chapter.

56-1606. MULTIFACILITY LOCATIONS. If an entity conducts, operates or maintains more than one (1) ICF licensed by the department, the entity shall pay the assessment for each ICF separately.

56-1607. TERMINATION OF ICF ASSESSMENTS. (1) The ICF assessment shall terminate and the department shall discontinue the imposition, assessment and collection of the ICF assessment if the plan amendment incorporating the payment in section 56-1604, Idaho Code, is not approved by CMS. In the event that CMS subsequently determines that the operation of this assessment program fails to abide by federal statute, regulation and/or CMS policy, the state shall return funds back to the providers on a pro rata basis of the assessments collected. The payment calculations in sections 56-1604 and 56-1609, Idaho Code, may be modified if necessary to obtain CMS approval of the plan amendment.

(2) Upon termination of the assessment, all collected assessment revenues, less any amounts expended by the department, shall be returned on a pro rata basis to ICFs that paid the ICF assessment.

56-1608. PENALTIES FOR FAILURE TO PAY INTERMEDIATE CARE FACILITY ASSESSMENT. (1) If an ICF fails to pay the full amount of an ICF assessment when due, there shall be added to the assessment, unless waived by the department for reasonable cause, a penalty equal to five percent (5%) of the amount of the assessment that was not paid when due. Any subsequent payments shall be credited first to unpaid assessment amounts rather than to penalty or interest amounts, beginning with the most delinquent installment.

(2) In addition to the penalty identified in subsection (1) of this section, the department may seek any of the following remedies for failure of any ICF to pay its assessment when due:

- (a) Withhold any medical assistance reimbursement payments until such time as the assessment amount is paid in full;
- (b) Suspend or revoke the ICF license; or
- (c) Develop a plan that requires the ICF to pay any delinquent assessment in installments.

1 56-1609. ANNUAL INTERMEDIATE CARE FACILITY ADJUSTMENT PAYMENTS. (1)
2 All ICFs shall be eligible for annual ICF adjustments.

3 (2) For the purpose of this section, "medicaid days" are days of ICF
4 services paid for by the Idaho medical assistance program for the applicable
5 state fiscal year.

6 (a) For state fiscal year 2011, medicaid days for each provider's cost
7 report ending in calendar year 2009 shall be utilized to determine the
8 ICF adjustment payment.

9 (b) For state fiscal year 2012, medicaid days for each provider's cost
10 report ending in calendar year 2010 shall be utilized to determine the
11 ICF adjustment payment.

12 (c) Adjustment payments for a new provider, not new ownership, without
13 a full year cost report shall be determined using medicaid patient day
14 information from the full calendar quarter of business prior to the rate
15 adjustment quarter.

16 (3) Adjustment payments shall be paid on an annual basis to reimburse
17 covered medicaid expenditures in the aggregate within the upper payment
18 limit.

19 (4) If a provider does not pay its annual assessment within thirty (30)
20 days after receipt of the department invoice, no further rate adjustment
21 payments shall be made to the provider until receipt of all assessments in
22 arrears. If a provider pays its annual assessment more than sixty (60) days
23 after receiving the department invoice, the subsequent adjustment payment
24 shall be reduced twenty percent (20%).

25 56-1610. RULEMAKING AUTHORITY. The department shall adopt rules to
26 implement the provisions of this chapter.

27 SECTION 27. That Section 72-803, Idaho Code, be, and the same is hereby
28 amended to read as follows:

29 72-803. CLAIMS OF ATTORNEYS AND PHYSICIANS AND FOR MEDICAL AND RELATED
30 SERVICES -- APPROVAL. Claims of attorneys and claims for medical services
31 and for medicine and related benefits shall be subject to approval by the
32 commission; provided however, that fees for physician services shall be set
33 using relative value units from the current year resource based relative
34 value system (RBRVS) as it is modified from time to time, multiplied by con-
35 version factors to be determined by the commission in rule. Factors will be
36 set for, at least, the following CPT code areas: medicine, surgery, physical
37 medicine, radiology, anesthesia and pathology. The fees shall be adjusted
38 each year using the same methodology as set forth in section 56-~~136~~265, Idaho
39 Code. In cases where RBRVS units are not available or have no relation to
40 industrial claims, relative value units for fees for physician services
41 shall be determined by the commission. Initial conversion factors shall be
42 determined by the commission no later than January 1, 2006, to be effective
43 April 1, 2006.

44 SECTION 28. Sections 24 and 25 of this act shall be in full force and ef-
45 fect on and after July 1, 2012. The provisions of Section 26 of this act shall
46 be null, void and of no force and effect on and after July 1, 2012.