DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **15-0004**

2. STATE **IDAHO**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01 July 2015

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1905(a)(6), 1905(a)(12) and 2110(a)(24) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
Total ($) Federal Funds
FFY 2015 ($0)
FFY 2016 ($0)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
13 through 13a-2 OF ATTACHMENT 4.19-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
13a through 13a-1 of ATTACHMENT 4.19-A

10. SUBJECT OF AMENDMENT:
The method by which the inpatient upper payment limit calculation for non-state government owned and privately owned hospitals is being revised.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ **GOVERNOR'S OFFICE REPORTED NO COMMENT**
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
LISA HETTINGER

14. TITLE:
Administrator

15. DATE SUBMITTED: 6/25/15

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DENISE CHUCKOVICH—DEPUTY DIRECTOR
450 WEST STATE STREET, 10TH FLOOR
P.O. BOX 83720
BOISE, IDAHO 83720-0036
PHONE 208-334-5500
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June 25, 2015

David Meacham
Regional Administrator
Division of Medicaid and Children's Health Operations
M/S RSX-200
701 Fifth Ave., Ste 1600
Seattle, WA 981014

Dear Mr. Meacham:

The State of Idaho is submitting a Medicaid State Plan Amendment (SPA), Transmittal #15-0004. We are requesting this amendment to our State Plan to update Attachment 4.19-A. The proposed changes will update our calculation for the inpatient upper payment limit calculation for non-state government owned and privately owned hospitals. The upper payment limit will be determined on an annual basis using two different approaches. The first approach identifies the upper limit through the application of Medicare's prospective payment system, which is a diagnosis related group (DRG) payment system. The second approach uses a cost-based approach. The approach identifying the highest positive difference between what Medicare would have paid compared to what Medicaid paid will be utilized for that year. We are requesting a proposed effective date of July 1, 2015.

Please add the enclosed pages in your copy of the Idaho State Medicaid Plan:

- Attachment 4.19-A, pages 13 – 13a2

Tribal solicitation was requested for this SPA. Please see the attached Tribal Representative Notification Letter. This letter was mailed, e-mailed, and posted to the Medicaid-Tribes website with a specified due date for any feedback.

There is not an anticipated fiscal impact with this SPA.

No public hearings have been scheduled at this time.

Idaho appreciates your review of these changes, and anticipates your approval of this amendment. Please direct any questions regarding this SPA to Robert Kellerman, Senior

Financial Specialist, Office of Reimbursement, Bureau of Financial Operations, Division of Medicaid at (208) 364-1994 or by e-mail at kellermr@dhw.id.gov.

Sincerely,

LISA HETTINGER
Administrator

LH/cc

conditions are met:

a. Total inpatient and outpatient covered charges are more than fifty thousand dollars ($50,000) in the fiscal year; or

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

02. Payment for Hospitals without Cost Settlement. Those out-of-state hospitals not cost settling with the state will have annually adjusted rates of payment no greater than seventy-five percent (75%) for inpatient covered charges. This rate represents an average inpatient reimbursement rate paid to Idaho hospitals.

03. Payment For Out Of State Hospitals That Perform Specialized Services Or Procedures Unavailable At Instate Hospitals. In cases where the Department determines that a Medicaid client is having access difficulty because there are no instate hospitals available that can perform the particular service or procedure needed, the Department may negotiate a payment rate with an out of state hospital that can perform the service or procedure needed, rather than cost settle with them. The Department will set a payment rate that will reimburse the hospital on a reasonable cost basis under Medicare cost reimbursement principles. The established payment ceiling will be 100% of costs, and the payment floor will be 30% of inpatient covered charges or 100% of costs, whichever is less. Outpatient covered charges will be reimbursed based on payment for hospitals without cost settlement, as outlined in Attachment 4.19-B.

457. SUPPLEMENTAL PAYMENTS

01. SUPPLEMENTAL PAYMENTS FOR NON-STATE GOVERNMENT-OWNED HOSPITALS.

Subject to the provisions of this section, eligible providers of Medicaid inpatient hospital services shall receive a supplemental payment each state fiscal year. Eligible providers are nonstate government-owned and/or operated hospitals, including critical access hospitals and district hospitals.

The supplemental payments are intended to be used to improve access to health care. The payments made to these facilities will be based on the aggregate difference in the actual amount paid by the Medicaid program and the amount that would have been paid under Medicare payment principles.

The upper payment limit will be determined on an annual basis using two different approaches. The approach identifying the highest difference between what Medicare would have paid and what Medicaid paid will be utilized for that year.

The first approach identifies the upper limit through the application of Medicare's prospective payment system, which is a diagnosis related group (DRG) payment system. The upper payment limit computes for each hospital the Medicare DRG payment amount for each Medicaid discharge by determining a Medicare equivalent case mix index based on Medicaid discharges.

This upper payment limit also uses a payment per discharge calculation of the amount of Medicare pass-through and add-on reimbursement including, but not limited to outlier, graduate medical education, organ acquisition, routine and ancillary passthrough, IME, DSH, and capital payments.

The Medicare pass-through and add-on reimbursement are identified from the Medicare cost report and adjusted for Medicaid where applicable. The hospital's Medicare payment per discharge, which includes the DRG and passthrough/ add-on amounts are applied to the number of Medicaid discharges. The latest available information is used for Medicare DRG, Medicare pass-through and add-on payments, Medicare discharges, and Medicaid discharges. Inflation factors are defined from Global Insight's CMS PPS Hospital Market Basket. The inflation factors are applied accordingly to determine individual hospitals Medicare payment for the UPL period. The sum of each hospital's estimated Medicare payment for Medicaid discharges is the aggregate upper payment limit for the NSGO hospital class.

The second approach uses a cost-based approach. The computation of the upper payment limit will utilize the most recently Medicaid settled cost report that settles services using Medicare principals of reimbursement. These principals calculate cost using routine cost per diems and ancillary cost to charge ratios from the Medicare cost report 2552-10, or it's successor. The calculated cost under Medicare reimbursement principles will be compared to the Medicaid payments to create a UPL gap. The UPL gap will be inflated to the state fiscal year utilizing a mid-point to mid-point method.

Supplemental payments made to the non-state governmental-owned hospitals that provide inpatient hospital services will be distributed to all hospitals within that group based on a hospital's percentage of Medicaid inpatient days to total inpatient days within the group.

The supplemental payments made to non-state government-owned and/or operated hospitals are subject to prior federal approval and a contractual commitment by the hospitals not to allow expenditures paid for by the supplemental payments to be included in costs used to set Medicaid hospital payment rates.

The supplemental payments shall not be subject to rules governing payments to hospitals found in IDAPA 16.03.09 (Effective 3/29/12). However, they shall not exceed the Medicaid upper payment limits for non-state government-owned and/or operated hospital payments. The Medicaid upper payment limit analysis will be performed prior to making the supplemental payments.

Distributed supplemental payments will be made by the end of each State fiscal year and will be calculated based on the previous calendar year's Medicaid payment data (e.g., For State fiscal year 2014, the 2012 calendar year will be used to calculate the Medicaid payment data.).

02. SUPPLEMENTAL PAYMENTS FOR PRIVATE HOSPITALS.

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

Subject to the provisions of this section, eligible providers of Medicaid inpatient hospital services shall receive a supplemental payment each state fiscal year. Eligible providers are private hospitals with emergency departments, and private hospitals that are categorized as "rehabilitation" or "psychiatric" as provided in section II.C. of the "Application for Hospital Licenses and Annual Report 2012" by the Bureau of Facility Standards of the Department of Health and Welfare.

The supplemental payments are intended to be used to improve access to health care. The payments made to these facilities will be based on the aggregate difference in the actual amount paid by the Medicaid program and the amount that would have been paid under Medicare payment principles.

The upper payment limit will be determined on an annual basis using two different approaches. The approach identifying the highest difference between what Medicare would have paid and what Medicaid paid will be utilized for that year.

The first approach identifies the upper limit through the application of Medicare's prospective payment system, which is a diagnosis related group (DRG) payment system. The upper payment limit computes for each hospital the Medicare DRG payment amount for each Medicaid discharge by determining a Medicare equivalent case mix index based on Medicaid discharges.

This upper payment limit also uses a payment per discharge calculation of the amount of Medicare pass-through and add-on reimbursement including, but not limited to outlier, graduate medical education, organ acquisition, routine and ancillary pass-through, IME, DSH, and capital payments.

The Medicare pass-through and add-on reimbursement are identified from the Medicare cost report and adjusted for Medicaid where applicable. The hospital's Medicare payment per discharge, which includes the DRG and pass-through/add-on amounts are applied to the number of Medicaid discharges. The latest available information is used for Medicare DRG, Medicare pass-through and add-on payments, Medicare discharges, and Medicaid discharges. Inflation factors are defined from Global Insight's CMS PPS Hospital Market Basket. The inflation factors are applied accordingly to determine individual hospitals Medicare payment for the UPL period. The sum of each hospital's estimated Medicare payment for Medicaid discharges is the aggregate upper payment limit for the private hospital class.

The second approach uses a cost-based approach. The computation of the upper payment limit will utilize the most recently Medicaid settled cost report that settles services using Medicare principals of reimbursement. These principals calculate cost using routine cost per diems and ancillary cost to charge ratios from the Medicare cost report 2552-10, or

it's successor. The calculated cost under Medicare reimbursement principles will be compared to the Medicaid payments to create a UPL gap. The UPL gap will be inflated to the state fiscal year utilizing a mid-point to mid-point method.

Supplemental payments made to the private hospitals that provide inpatient hospital services will be distributed to all hospitals within that group based on a hospital's percentage of Medicaid inpatient days to total inpatient days within the group.

The supplemental payments shall not be subject to rules governing payments to hospitals found in IDAPA 16.03.09 (Effective 3/29/12). However, they shall not exceed the Medicaid upper payment limits private hospital payments. The Medicaid upper payment limit analysis will be performed prior to making the supplemental payments.

Distributed supplemental payments will be made by the end of each State fiscal year and will be calculated based on the previous calendar year's Medicaid payment data (e.g., For State fiscal year 2014, the 2012 calendar year will be used to calculate the Medicaid payment data.).

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LISA HETTINGER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

May 22, 2015

Dear Tribal Representative:

This letter is to inform you Idaho Medicaid intends to submit a State Plan Amendment (SPA), to the Centers for Medicare and Medicaid Services (CMS). The proposed amendment is in Attachment 4.19-A, Section 457 of the Idaho State Plan.

The proposed changes will update our calculation for the inpatient upper payment limit calculation for non-state government owned and privately owned hospitals. The upper payment limit will be determined on an annual basis using two different approaches. The first approach identifies the upper limit through the application of Medicare's prospective payment system, which is a diagnosis related group (DRG) payment system. The second approach uses a cost-based approach. The approach identifying the highest positive difference between what Medicare would have paid compared to what Medicaid paid will be utilized for that year.

The effective date for this change is July 1, 2015.

We encourage you to provide feedback within 30 days from May 22, 2015. Please provide your feedback regarding these changes to Robert Kellerman, Office of Reimbursement, Bureau of Financial Operations, Division of Medicaid at (208) 364-1994, or by e-mail at kellermr@dhw.id.gov.

Sincerely,

LISA HETTINGER
Administrator

LH/rk