

ATTACHMENT 4 - 19-B

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Minimum payment to non-institutional providers of services for individuals eligible for Medicare and Medicaid will be as follows: Medicaid will pay the lesser of the Medicaid allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together.

Except as otherwise noted in this section State developed fee schedule rates are the same for both governmental and private providers of the same service (medical services). The fee schedule and any annual/periodic adjustments to the fee schedule are published on the Department of Health and Welfare website:

<http://www.healthandwelfare.idaho.gov>

DEFINITIONS In determining hospital reimbursement on the basis either of Customary Charges or the Reasonable Cost of outpatient services under Medicaid guidelines, whichever is less, the following will apply:

- **Customary Charges.** Customary Charges reflect the regular rates for ~~inpatient or~~ outpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services billed to the Title XIX program. ~~No more than ninety-one and one-seventh percent (91.7%) of covered charges will be reimbursed for the separate operating costs for total outpatient services at the time of final cost settlement for any fiscal year with the exception set forth in subsection 453 in Attachment 4.19-A.~~
- **Reasonable Costs.** Except as otherwise provided in subsection 453 in Attachment 4.19-A, Reasonable Costs includes all necessary and ordinary costs incurred in rendering the services related to patient care which a prudent and cost-conscious hospital would pay for a given item or service, which do not exceed the Title XIX cost limit.
 - a. ~~No more than one hundred one percent (101%) of cost will be reimbursed to in-state Critical Access Hospitals (CAHs) as defined in 42 U.S.C. 1395i-4(c)(2)(B). No more than eighty-seven percent (87%) of cost will be reimbursed to out-of-state hospitals, and no more than one hundred percent (100%) of cost will be reimbursed to state-owned hospitals. Reimbursement to all other in-state hospitals shall be at a rate of no more than one hundred percent (100%) of cost, or at a rate otherwise provided in Section 56-265, Idaho Code.~~

Establishment of payment rates for the following types of care are provided under the program:

1. Inpatient Hospital Services: Refer to Attachment 4.19-A.
2. Outpatient Services:
 - a. **Outpatient Hospital Services-** must be provided on-site. Covered outpatient services and items will be paid in behalf of Medical Assistance clients at the lesser of customary charges or the reasonable cost of inpatient services and in accordance with the upper payment limits specified in Chapter 42 of the Code of Federal Regulations Section 447.321. 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.
 - i. Payment to hospitals for clinical diagnostic laboratory tests rendered to outpatients and non-patients will be paid at a rate not to exceed Medicare's fee schedule for each of those

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types of services. Exceptions included in Section 2303(d) of the Deficit Reduction Act will be paid at a rate not to exceed the Department's Medical Assistance Unit, or its successor's, fee schedule.

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- Case-Mix Index. The Case-Mix Index for a hospital is the average weight of values assigned to a range of diagnostic related groups, including but not limited to, those used in the Medicare system or adjoining states and applied to Medicaid discharges included in a hospital's fiscal year end settlement. The index will measure the relative resources required to treat Medicaid inpatients. The Case-Mix Index of the Current Year will be divided by the index of the Principal Year to assess the percent change between the years.
- Charity Care. Charity Care is care provided to individuals who have no source of payment third-party or personal resources.
- Children's Hospital. A Children's Hospital is a Medicare certified hospital as set forth in 42 CFR Section 412.23 (d)
- Critical Access Hospitals (CAH). A rural hospital with twenty-five (25) or less beds as set forth in 42 CFR Section 485.602.
- Cost Report. A Cost Report is the complete Medicare cost reporting form HCFA 2552, or its successor, as completed in full and accepted by the Intermediary for Medicare cost settlement and audit.
- Current Year. Any hospital cost reporting period for which Reasonable Cost is being determined will be termed the Current Year.
- ~~Customary Charges. Customary Charges reflect the regular rates for inpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services billed to the Title XIX program. No more than ninety one and seven tenths percent (91.7%) of covered charges will be reimbursed for the separate Operating Costs for either total inpatient services or total outpatient services at the time of final cost settlement for any fiscal year with the exception set forth in subsection 453. For in-state hospitals that are not specified in Section 56-1408 (effective 07/01/2011), Idaho Code, no more than one hundred percent (100%) of covered charges will be reimbursed. No more than one hundred one percent (101%) of covered charges will be reimbursed to Critical Access Hospitals (CAH) for in-state private hospitals. No more than eighty seven and one tenth (87.1%) of covered charges will be reimbursed to out-of-state hospitals.~~
- Disproportionate Share Hospital (DSH) Allotment Amount. The Disproportionate Share Hospital (DSH) Allotment Amount is determined by CMS which is eligible for federal matching funds in the federal fiscal period for disproportionate share payments.
- Disproportionate Share Threshold. The Disproportionate Share Threshold shall be: a. the arithmetic mean plus one (1) standard deviation of the Medicaid Inpatient Utilization Rates of all Idaho hospitals; or, b. a Low Income Utilization Rate exceeding twenty-five percent (25%).

- Reasonable Costs. Except as otherwise provided in section 453, Reasonable Costs includes all necessary and ordinary costs incurred in rendering the services related to patient care which a prudent and cost-conscious hospital would pay for a given item or service, which do not exceed the Title XIX cost limit.
 - a. No more than one hundred one percent (101%) of cost will be reimbursed to in-state Critical Access Hospitals (CAHs) as defined in 42 U.S.C. 1395i-4(c)(2)(B). No more than eighty-seven percent (87%) of cost will be reimbursed to out-of-state hospitals, and no more than one hundred percent (100%) of cost will be reimbursed to state-owned hospitals. Reimbursement to all other in-state hospitals shall be at a rate of no more than ninety one percent (91%) of cost.
- ~~Reimbursement Floor Percentage. The floor calculation for out-of-state hospitals is seventy three and five tenths percent (73.5%) of Medicaid cost, and the floor calculation for in-state Critical Access Hospitals (CAH) hospitals is one hundred and one percent (101%) of Medicaid costs. For in-state hospitals that are not specified in section 56-1408 Idaho code effective 7-1-2010, the floor calculation is eighty five percent (85%) of Medicaid costs. For in-state hospitals that are specified in section 56-1408 Idaho code, passed in the 2009 Legislative session, the floor calculation is seventy seven and four tenths (77.4%) of Medicaid costs.~~
- TEFRA. TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248.
- Uninsured Patient Costs. For purposes of determining additional costs beyond uncompensated Medicaid costs that may be reimbursed as a DSH payment without exceeding the State Allotment Amount, only inpatient costs of uninsured patients will be considered.
- Upper Payment Limit. The Upper Payment Limit for hospital services shall be as defined in Chapter 42 of the Code of Federal Regulations.

458. INSTITUTIONS FOR MENTAL DISEASE (IMD). ~~Except for individuals under twenty-two (22) years of age which are contracted with the Department under the authority of the Division of Family and Community Services and certified by the Health Care Financing Administration, no services related to inpatient care in a freestanding psychiatric hospital will be covered. A hospital of seventeen (17) beds or more that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. This definition does not apply to Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IIDs).~~

01. PRIVATE FREESTANDING MENTAL HEALTH FACILITIES. ~~IMD~~ ~~certified~~ Services provided by an in-state private, freestanding mental health hospital facilities facility that is an institution for mental disease, as defined in 42 U.S.C. 1396d(i), will be reimbursed for inpatient services at a rate not to exceed ninety-one percent (91%) of the current Medicare rate effective for those dates of service on which the participant was a resident of that facility within federally allowed reimbursement under the Medicaid program. The rate shall be effective until June 30, 2021. On or after state fiscal year 2020, the department shall equitably reduce net reimbursements for in-state hospital institutions for mental disease by amounts targeted to reduce general fund needs for hospital payments. Out-of-state hospital institutions for mental disease shall be reimbursed at ninety-five percent (95%) of cost.

459. AUDIT FUNCTION. Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Title XVIII and Title XIX purposes. The Department may elect to perform an audit even though the Medicare Intermediary does not choose to audit the facility.

460. 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 recipients. 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.