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16.03.10 - RULES GOVERNING MEDICAID PROVIDER REIMBURSEMENT IN IDAHO

000. LEGAL AUTHORITY.
Title XIX (Medicaid) of the Social Security Act, as amended, is the basic authority for administration of the federal program (see 42 CFR Part 447). Title 56, Chapter 1, Idaho Code, establishes standards for provider payment. Section 56-202, Idaho Code, provides that the Department is responsible for administering the program. Further it authorizes the Department to take necessary steps for its proper and efficient administration. (7-1-99)T

01. General. (7-1-93)

a. Fiscal administration of the Idaho Title XIX Medicaid Program will be in accordance with these rules and the Federal (42 CFR Part 447 Provider Reimbursement Manual (PRM) Part I and Part II, HCFA Publication 15-1 and 15-2, which is hereby incorporated by reference. These materials are available from HCFA, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the internet @ http://www.access.gpo.gov/nara/cfr/cfr-table-search.html). The provisions shall apply unless otherwise authorized. (7-1-99)T

b. Generally accepted accounting principles, concepts and definitions shall be followed in determining acceptable accounting treatments except as otherwise provided. (1-16-80)

02. Compliance As Condition Of Participation. Compliance with the provisions in this chapter, its amendments, and additions is required for participation in the Idaho Title XIX (Medicaid) Program. (7-1-99)T

001. TITLE.
The rules in this chapter are to be cited in full as Idaho Department of Health and Welfare Rules, IDAPA 16.03.10, "Rules Governing Medicaid Provider Reimbursement in Idaho". (12-31-91)

002. REIMBURSEMENT PROVISIONS FOR STATE OWNED OR OPERATED ICF/MR FACILITIES.
Provisions of these rules do not apply to ICF/MR facilities owned or operated by the state of Idaho. Reimbursement of such facilities will be governed by the principles set forth in the PRM, with the exception of depreciation. Assets of such facilities need not be depreciated if they have an acquisition or historical cost of less than five thousand dollars ($5,000). (7-1-99)T

003. ADMINISTRATIVE APPEALS.
Hearings will be conducted in conformance with IDAPA 16.05.03, "Rules Governing Contested Cases Proceedings And Declaratory Rulings". (7-1-99)T

004. DEFINITIONS.

01. Accrual Basis. An accounting system based on the matching principle. Revenues are recorded when they are earned; expenses are recorded in the period incurred. (1-16-80)

02. Allowable Cost. Costs which are reimbursable, and sufficiently documented to meet the requirements of audit. (1-16-80)

03. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (1-16-80)

04. Appraisal. The method of determining the value of property as determined by a MAI appraisal. The appraisal must specifically identify the values of land, buildings, equipment and goodwill. (9-15-84)

05. Assets. Economic resources of the contractor, recognized and measured in conformity with generally accepted accounting principles. (1-1-82)

06. **Bad Debts**. Amounts due to provider as a result of services rendered, but which are considered uncollectible. (1-16-80)

07. **Bed-Weighted Median**. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (7-1-99)T

08. **Beneficiaries**. Persons who are eligible for and receive benefits under federal health insurance programs such as Title XVIII and Title XIX. (1-16-80)

09. **Betterments**. Improvements to assets which increase their utility or alter their use. (1-16-80)

10. **Capitalize**. The practice of accumulating expenditures related to long-lived assets which will benefit later periods. (1-16-80)

11. **Case Mix Component**. The portion of the facility's rate, direct care component, that is determined from quarterly case mix indices. The case mix component of a facility's rate is established at the beginning of each calendar quarter, based on the case mix indices calculated on the picture date of the preceding quarter. (7-1-99)T

12. **Case Mix Index**. A numeric score assigned to each facility resident, based on the resident's physical and mental condition, which projects the amount of relative resources needed to provide care to the resident. (7-1-99)T

a. Facility Wide Case Mix Index. The average of the entire facility's case mix indices identified at each picture date during the cost reporting period. If case mix indices are not available for applicable quarters due to lack of data, case mix indices from available quarters will be used. (7-1-99)T

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG's classification. Medicaid or non-Medicaid status will be based upon information contained in claims and MDS databases. To the extent that Medicaid identifiers are found to be incorrect at the time of the audit, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. (7-1-99)T

c. State-Wide Average Case Mix Index. The simple average of all facilities "facility wide" case mix indices used in establishing the reimbursement limitation July 1 of each year. The state-wide case mix index will be calculated annually during each July 1 rate setting. (7-1-99)T

13. **Common Ownership**. An individual, individuals, or other entities which have equity, or evidence ownership in two (2) or more organizations which conduct business transactions with each other. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider. (7-1-99)T

14. **Compensation**. The total of all remuneration received, including cash, expenses paid, salary advances, etc. (1-16-80)

15. **Control**. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution. (7-1-99)T

16. **Cost Center**. A "collection point" for expenses incurred in the rendering of services, supplies, or material which are related or so considered for cost-accounting purposes. (1-16-80)

17. **Cost Component**. The portion of the facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a facility's rate is established annually at July 1 of each year. (7-1-99)T

18. Cost Reimbursement System. A method of fiscal administration of Title XIX which compensates the provider on the basis of expenses incurred. (1-16-80)

19. Cost Report. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (7-1-99)T

20. Cost Statements. An itemization of costs and revenues, presented on the accrual basis, which is used to determine cost of care for facility services for a specified period of time. These statements are commonly called income statements. (1-16-80)

21. Costs Related To Patient Care. All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. (7-1-99)T

22. Costs Not Related To Patient Care. Costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are not allowable unless it can be specifically shown that they relate to patient care and for the operation of the nursing facility. (7-1-99)T

23. Customary Charges. Customary charges are the regular rates for various services which are recorded for Medicare beneficiaries and charges to patients liable for such charges. Those charges are to be adjusted downward, where the provider does not impose such charges on most patients liable for payment on a charge basis or, fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt (see Chapter 3, Sections 310 and 312, PRM). (7-1-99)T

24. Day Treatment Services. Day treatment services are developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the provider. However, day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for or required to be provided by a school or other entity. (7-1-97)

25. Department. The Department of Health and Welfare of the state of Idaho. (1-16-80)

26. Depreciation. The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (1-1-82)

27. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost finding principles and consisting of the following: (7-1-99)T

a. Direct nursing salaries which include the salaries of registered nurses, licensed professional nurses, certified nurse's aides, and unit clerks; and (7-1-99)T

b. Routine nursing supplies; and (7-1-99)T

c. Nursing administration; and (7-1-99)T

d. Direct portion of Medicaid related ancillary services; and (7-1-99)T

e. Social services; and (7-1-99)T

f. Raw food; and (7-1-99)T

g. Employee benefits associated with the direct salaries. (7-1-99)T

28. **Director**. The Director of the Department of Health and Welfare or his designee. (1-1-82)

29. **Equity**. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (9-15-84)

30. **Facility**. An entity which contracts with the Director to provide services to recipients in a structure owned, controlled, or otherwise operated by such an entity, and which entity is responsible for operational decisions in conjunction with the use of the term "facility": (1-1-82)

a. The term "Nursing Facility" or "NF" is used to describe all non-ICF/MR facilities certified to provide care to Medicaid and Medicare patients; (2-1-91)

b. "Free-standing Nursing Facility" means a skilled nursing facility, as defined in and licensed under Chapter 13, Title 39, Idaho Code, which is not owned, managed, or operated by, nor is otherwise a part of a hospital, as defined in Section 39-1301(a), Idaho Code; or (9-28-90)

c. "Hospital-based facility" means a nursing facility, as defined in and licensed under Chapter 13, Title 39, Idaho Code, which is owned, managed, or operated by, or is otherwise a part of a hospital, as defined in Section 39-1301(a), Idaho Code. (7-1-97)

d. "Rural Hospital-Based Nursing Facilities." Those hospital-based nursing facilities not located within metropolitan statistical area (MSA) as defined by the United States Bureau of Census. (7-1-99)T

e. "Urban Hospital-Based Nursing Facilities." Those hospital-based nursing facilities located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (7-1-99)T

31. **Fiscal Year**. The business year of an organization. (1-16-80)

32. **Forced Sale**. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (11-4-85)

33. **Funded Depreciation**. Amounts deposited or held which represent recognized depreciation. (1-16-80)

34. **GAAP**. Generally accepted accounting principles, pronounced "gap". (1-16-80)

35. **Generally Accepted Accounting Principles**. Those concepts, postulates, axioms, etc., which are considered standards for accounting measurement. (1-16-80)

36. **Goodwill**. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is nonallowable, nonreimbursable expense. (9-15-84)

37. **Historical Cost**. The actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies. (1-1-82)

38. **ICF/MR**. An intermediate care facility for the mentally retarded. (9-15-84)

39. **ICF/MR Living Unit**. The specific property or portion thereof that an ICF/MR uses to house patients. (7-1-97)

40. **Improvements**. Improvements to assets which increase their utility or alter their use. (1-16-80)

41. **Indirect Care Costs**. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (7-1-99)T

a. Administrative and general care costs: and (7-1-99)T

b. Activities; and (7-1-99)T

c. Central service and supplies; and (7-1-99)T

d. Laundry and linen; and (7-1-99)T

e. Dietary (non-"raw food" costs); and (7-1-99)T

f. Plant operations and maintenance (excluding utilities); and (7-1-99)T

g. Medical records; and (7-1-99)T

h. Employee benefits associated with the indirect salaries; and (7-1-99)T

i. Housekeeping; and (7-1-99)T

j. Other costs not included in direct care costs or costs exempt from cost limits. (7-1-99)T

42. **Inflation Adjustment**. Cost used in establishing a facility's reimbursement rate shall be indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. (7-1-99)T

43. **Inflation Factor**. For use in establishing nursing facility rates, the inflation factor is the Skilled Nursing Facility (SNF) Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. (7-1-99)T

44. **Interest**. The cost incurred for the use of borrowed funds. (1-16-80)

45. **Interest On Capital Indebtedness**. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are differentiated from those related to current indebtedness by the payback period of the related debt. (1-16-80)

46. **Interest On Current Indebtedness**. The costs incurred for borrowing funds which will be used for "working capital" purposes. These costs are differentiated from others by the fact that the related debt is scheduled for repayment within one (1) year. (1-16-80)

47. **Interest Rate Limitation**. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/MR facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (1%) at the date the loan is made. (7-1-99)T

48. **Interim Reimbursement Rate (IRR)**. A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (10-22-93)

49. **Intermediary**. Any organization which administers the Title XIX program; in this case the Department of Health and Welfare. (1-16-80)

50. Intermediate Care Facility For The Mentally Retarded. A habilitative facility designed and operated to meet the educational, training, habilitative and intermittent medical needs of the developmentally disabled. (9-15-84)

51. Keyman Insurance. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. (1-16-80)

52. Lease. A contract arrangement for use of another's property, usually for a specified time period, in return for period rental payments. (1-16-80)

53. Leasehold Improvements. Additions, adaptations, corrections, etc., made to the physical components of a building or construction by the lessee for his use or benefit. Such additions may revert to the owner. Such costs are usually capitalized and amortized over the life of the lease. (1-16-80)

54. Level Of Care. The classification in which a patient/resident is placed following a medical/social review decision. (1-16-80)

55. Licensed Bed Capacity. The number of beds which are approved by the Licensure and Certification Agency for use in rendering patient care. (1-16-80)

56. Lower Of Cost Or Charges. Payment to providers (other than public providers furnishing such services free of charge or at nominal charges to the public) shall be the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers which furnish services free of charge or at a nominal charge shall be reimbursed fair compensation; which is the same as reasonable cost. (7-1-99)T

57. MAI Appraisal. An appraisal which conforms to the standards, practices, and ethics of the American Institute of Real Estate Appraisers and is performed by a member of the American Institute of Real Estate Appraisers. (9-15-84)

58. Major Movable Equipment. Major movable equipment means such items as beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are: (12-28-89)

a. A relatively fixed location in the building; (11-4-85)

b. Capable of being moved, as distinguished from building equipment; (11-4-85)

c. A unit cost of five thousand dollars ($5000) or more; (7-1-99)T

d. Sufficient size and identity to make control feasible by means of identification tags; and (11-4-85)

e. A minimum life of three (3) years. (7-1-99)T

59. Minimum Data Set (MDS). A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The version of the document initially used for rate setting is version 2.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary. (7-1-99)T

60. Medicaid. The 1965 amendments to the Social Security Act (P.L. 89-97), as amended. (1-1-82)

61. Medicaid Related Ancillary Costs. For the purpose of these rules, those services considered to be ancillary by Medicare cost reporting principles. Medicaid related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid residents by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid related ancillaries. (7-1-99)T

62. Minor Movable Equipment. Minor movable equipment includes such items as wastebaskets,

bedpans, syringes, catheters, silverware, mops, buckets, etc. Oxygen concentrators used in lieu of bottled oxygen shall, at the facility's option, be considered minor movable equipment with the cost thereof reported as a medical supply. The general characteristics of this equipment are: (12-28-89)

a. In general, no fixed location and subject to use by various departments of the provider's facility; (11-4-85)

b. Comparatively small in size and unit cost under five thousand dollars ($5000); (7-1-99)T

c. Subject to inventory control; (11-4-85)

d. Fairly large quantity in use; and (11-4-85)

e. Generally, a useful life of less than three (3) years. (7-1-99)T

63. **Necessary**. The purchase of goods or services that is required by law, prudent management, and for normal, efficient and continuing operation of patient related business. (7-1-99)T

64. **Net Book Value**. The historical cost of an asset, less accumulated depreciation. (1-1-82)

65. **New Bed**. A bed is considered new if it is an additional nursing facility bed that is licensed subsequent to July 1, 1999. (7-1-99)T

66. **Nominal Charges**. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the related services. (7-1-99)T

67. **Nonambulatory**. Unable to walk without assistance. (11-4-85)

68. **Nonprofit Organization**. An organization whose purpose is to render services without regard to gains. (1-1-82)

69. **Normalized Per Diem Cost**. Refers to direct care costs that have been adjusted based on the facility's case mix index for purposes of making the per diem cost comparable among facilities. Normalized per diem costs are calculated by dividing the facility's direct care per diem costs by its facility-wide case mix index, and multiplying the result by the statewide average case mix index. (7-1-99)T

70. **Nursing Home Facility**. A "Nursing Facility" or "NF". See facility. (9-28-90)

71. **Nursing Facility Inflation Rate**. The most specific skilled nursing facility inflation rate applicable to Idaho established by Data Resources, Inc. or its successor. If a state or regional index has not been implemented, the national index will be used. (7-1-99)T

72. **Ordinary**. Ordinary means that the costs incurred are customary for the normal operation of the business. (7-1-99)T

73. **Patient Day**. A calendar day of care which will include the day of admission and exclude the day of discharge unless discharge occurs after 3:00 p.m. or it is the date of death, except that, when admission and discharge occur on the same day, one (1) day of care shall be deemed to exist. (1-1-82)

74. **Picture Date**. A point in time when case mix indices are calculated for every facility based on the residents in the facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the facility's rate for the next quarter. (7-1-99)T

75. **Private Rate**. Rate most frequently charged to private patients for a service or item. (1-16-80)

76. **PRM**. The Providers Reimbursement Manual, a federal publication which specifies accounting

treatments and standards for the Medicare program, HCFA Publications 15-1 and 15-2, which are incorporated by reference into these rules. (7-1-99)T

77. **Property Costs**. The total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. (9-15-84)

78. **Property Rental Rate**. A rate paid per Medicaid patient day to other than hospital based nursing homes in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/MR facilities. (7-1-97)

79. **Proprietary**. An organization operated for the purpose of monetary gains. (1-16-80)

80. **Provider**. A licensed and certified skilled nursing or intermediate care facility which renders care to Title XIX recipients. (1-16-80)

81. **Prudent Buyer**. A prudent buyer is one who seeks to minimize cost when purchasing an item of standard quality or specification (PRM, Chapter 2100). (7-1-99)T

82. **Public Provider**. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (7-1-99)T

83. **Related To Provider**. The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (7-1-99)T

84. **Raw Food**. Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (7-1-99)T

85. **Reasonable Property Insurance**. Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year shall not be considered reasonable. (11-4-85)

86. **Recipient**. An individual determined eligible by the Director for the services provided in the state plan for Medicaid. (1-1-82)

87. **Related Entities**. The provider, to a significant extent, is associated or affiliated with, or is controlled by, or has control of another entity. (1-16-80)

88. **Resource Utilization Groups (RUG's)**. A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. For purposes of initial rate setting, RUG's III, version 5.12, 34 Grouper, nursing weights only, with index maximization will be used for grouping residents and is hereby incorporated into these rules. The RUG's Grouper is available from HCFA, 7500 Security Blvd., Baltimore, MD, 21244-1850. Subsequent versions of RUG's, or its successor, will be evaluated and may be incorporated into the rate setting process as necessary. (7-1-99)T

89. **Skilled Nursing Care**. The level of care for patients requiring twenty-four (24) hour skilled nursing services. (1-16-80)

90. **Skilled Nursing Facility**. A nursing care facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and certified as a "Nursing Facility" under Title XVIII. (9-28-90)

91. **Title XVIII**. The Medicare program administered by the federal Social Security Administration. (1-16-80)

92. **Title XIX**. The medical assistance program known as Medicaid administered by the state of Idaho,

Department of Health and Welfare. (1-16-80)

93. **Utilities**. All expenses for heat, electricity, water and sewer. (9-15-84)

005. -- 049. (RESERVED).

050. CRITERIA FOR PARTICIPATION IN THE IDAHO TITLE XIX PROGRAM.

01. **Application For Participation And Reimbursement**. Prior to participation in the Medicaid Program the Licensure and Certification Section of the Division of Health, Department of Health and Welfare or its successor organization, certifies a facility for participation in the Program. Their recommendations are forwarded to the Division of Welfare, Division of Medicaid or its successor organization, for approval. The Division of Medicaid or its successor organization issues a provider number to the facility which becomes the primary provider identification number. The Division of Medicaid or its successor organization will need to establish an interim rate for the new applicant facility. This facility is now authorized to offer services at the level for which the provider agreement was issued. (7-1-99)T

02. **Reimbursement**. The reimbursement mechanism for payment to provider facilities is specified in Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, "Rules Governing Medical Assistance". The Medical Assistance Program will not reimburse a facility until it is certified, has a signed agreement for participation and an established interim per diem rate. (4-28-89)

051. -- 059. (RESERVED).

060. PROPERTY REIMBURSEMENT.
Facilities other than hospital based nursing facilities will be paid a property rental rate, and shall also be reimbursed the Medicaid share of property taxes and reasonable property insurance. The Medicaid share is determined by the ratio of Medicaid patient days to total patient days. The property rental rate includes compensation for major movable equipment but not for minor movable equipment. However, the property rental rate for ICF/MR shall not include compensation for major 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 for a NF, an interim rate for property reimbursement shall be set to approximate the property rental rate as determined by Sections 56-108 and 56-109, Idaho Code. (7-1-97)

01. **Property Rental Rate**. The property rental rate is based upon current construction costs, the age of the facility, the type of facility, and major expenditures made to improve the facility, or a rate based upon property costs as of January 1, 1985. The amount paid for each Medicaid day of care will be phased in according to Section 061., and, beginning April 1, 1985, shall be:

R = "Property Base" x 40 - "Age" / 40 x "change in building costs" where: (12-31-91)

a. "R" = the property rental rate. (11-4-85)

b. "Property Base" = thirteen dollars and nineteen cents ($13.19) beginning October 1, 1996 for all freestanding nursing facilities but not ICF/MR facilities. Beginning October 1, 1996, the property base rate for ICF/MR - living units shall be eleven dollars and twenty-two cents ($11.22) except for ICF/MR living units not able to accommodate residents requiring wheelchairs. Property base = seven dollars and twenty-two cents ($7.22) for ICF/MR living units not able to accommodate residents requiring wheelchairs. (7-1-97)

c. "Change in building costs" = 1.0 from October 1, 1996, through December 31, 1996. Beginning January 1, 1997, "change in building costs" 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 published by the Marshall Swift Valuation Service or the consumer price index for renter's costs whichever is greater. For freestanding NF facilities, the index available in September of the prior year will be used; for ICF/MR facilities, the most recent index available when it is first necessary to set a prospective rate for a period that includes all or part of the calendar year, will be used.(7-1-97)

d. "Age" of facility - The effective age of the facility in years shall be set 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: (11-4-85)

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 age shall be set 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 contract, and original notes of indebtedness. An age shall be determined for each building. A weighted average using the age and square footage of the buildings shall become the effective age of the facility. The age of each building shall be based upon the date when construction on that building was completed. This age shall be adjusted to reflect major building expansion or remodeling prior to April 1, 1985, if that expenditure was large enough to reduce the age of the facility by two (2) or more years according to the following formula:

r	=	A x E / S x C

Where:

r	=	Reduction in the age of the facility in years.
A	=	Age of the building at the time when construction was completed.
E	=	Actual expenses for the construction provided that the total costs must have been incurred within twenty-four (24) months of the completion of the construction.
S	=	The number of square feet in the building at the end of construction.
C	=	The cost of construction for the buildings in the year when construction was completed according to the schedule in Subsection 060.01.d.ii.

If the result of this calculation, "r" 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 for rate setting purposes. In no case will the age be less than zero (0). (12-28-89)

ii. Historical Nursing Home Construction Cost per Square Foot for Purposes of Evaluating Facility Age.

Age	Year	Cost		Age	Year	Cost		Age	Year	Cost
1	1984	49.72		**2**	1983	47.61		**3**	1982	45.99
4	1981	44.51		**5**	1980	41.77		**6**	1979	38.58
7	1978	35.20		**8**	1977	31.54		**9**	1976	29.43
10	1975	27.38		**11**	1974	25.17		**12**	1973	23.58
13	1972	21.37		**14**	1971	19.57		**15**	1970	18.27
16	1969	17.52		**17**	1968	16.32		**18**	1967	15.41
19	1966	14.86		**20**	1965	14.22		**21**	1964	13.87
22	1963	13.65		**23**	1962	13.20		**24**	1961	12.90
25	1960	12.77		**26**	1959	12.58		**27**	1958	12.23
28	1957	12.05		**29**	1956	11.84		**30**	1955	11.32

(10-22-93)

iii. For rates paid after June 30, 1989, the effective age of a facility shall be further adjusted when the cost of major repairs, replacement, remodeling, or renovation of a building initiated after April 1, 1985, results in the change in age by at least one (1) year when applied to the formula in Subsection 060.01.d.i. However, such change shall not decrease the effective age of a facility beyond the point where the increase in the property rental rate is greater than three-fourths (3/4) of the difference between the property rental rate "r" for a new facility at the time of the proposed rate revision and the property rental rate for which the facility was eligible immediately before the adjustment. The cost used for "C" shall be adjusted according to costs published by Marshall Swift Valuation Service to reflect current construction costs for average Class D convalescent hospitals. It is the provider's responsibility to notify the Department and document costs. The Department will adjust the age after documentation of costs. (10-22-93)

iv. In the event that new requirements are imposed by state or federal agencies, the Department shall reimburse the expenditures directly related to these requirements as an increase in the property rental rate if the expense is in excess of one hundred dollars ($100) per bed. If the cost related to the requirement is less than one hundred dollars ($100) per bed, the Department shall, within twelve (12) months of verification of expenditure, reimburse the Medicaid share of the entire cost of such new requirements, as a one (1) time payment to the facility. (7-1-97)

v. At no time shall the property rental rate paid to a facility be less than the greater of the rate allowable to that facility on December 31, 1988, the rate allowable immediately following the first opening of a new facility after December 31, 1988, or the rate allowable immediately following the last, if any, age revision after December 31, 1988. However, subsequent to the application of this provision, before any property rental rate increase may be made for current or successor operators, the final settlement amount of any increase in the property rental rate will first be offset by an amount equal to the impact on final settlement of any rate decrease that would have occurred if the provisions of Subsections 060.01.d.iii. and 060.01.d.iv. of these rules had not been applied. This is intended to allow the postponement of the financial burden to providers of property rental rate decreases and to allow an equal offset of the financial burden to the state of subsequent property rate increases for a current or successor provider. (7-1-97)

vi. Effective July 1, 1991, for freestanding nursing facilities, and effective October 1, 1996, for ICF/MR 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 060.01 of these rules. This revised age shall not increase over time. (7-1-97)

02. Grandfathered Rate. A "grandfathered property rental rate" for existing free-standing nursing facilities will be determined by dividing the audited allowable annualized property costs, exclusive of taxes and insurance, for assets on hand as of January 1, 1985, by the total patient days in the period July 1, 1984, through June 30, 1985. (7-1-97)

a. Prior to audit settlement, the interim rate for property costs allowable as of January 1, 1985, shall be used to approximate the grandfathered rate. (11-4-85)

b. The grandfathered property rental rate shall be adjusted to compensate the facility for the property costs of major repairs, replacement, expansion, remodeling or renovation initiated prior to April 1, 1985, and completed during calendar year 1985. (12-28-89)

c. Beginning July 1, 1989, facilities receiving grandfathered rates may have those rates adjusted for modifications related to major repairs, replacement, expansion, remodeling, or renovation initiated after January 1, 1986, if the cost of these modifications would be sufficient to reduce the age of the facility by one (1) year or more according to Subsection 060.01.d.i. The grandfathered rate shall be revised after completion of modifications and shall be the greater of: (12-31-91)

i. The grandfathered rate previously allowed; or (12-28-89)

ii. The actual per diem property costs of amortization, depreciation and interest not applicable to the

modifications for the audit period in which the modifications were completed plus the per diem rate of the first year amortization of the cost of these modifications when amortized over American Hospital Association guideline useful life or lives. However, no change in the grandfathered rate shall be allowed to change that rate by more than three-fourths (3/4) of the difference between the previous grandfathered rate and the property rental rate that would be paid for a new building at the time of the proposed rate revision. (12-28-89)

d. The facility will be reimbursed a rate which is the higher of the grandfathered property rental rate as determined according to provisions of Subsection 060.02 or the property rental rate determined according to Subsections 060.01, 060.03, or 060.05 and Section 061. (12-31-91)

03. Leased Freestanding Nursing Facilities. Freestanding nursing facilities with leases will not be reimbursed in the same manner specified in Subsections 060.01 and 060.02 of these rules. Provisions in this Section do not apply to reimbursement of home office costs. Home office costs shall be paid based on reasonable cost principles. (7-1-97)

a. Facilities with leases entered into on or after March 30, 1981, are to be reimbursed in the same way as owned facilities with ownership costs being recognized instead of lease costs. (11-4-85)

b. Facilities with leases entered into prior to March 30, 1981, will not be subject to reimbursement according to the provisions of Subsections 060.01 or 060.02 or Section 061. Their property rental rate per day of care will be the sum of the annualized allowed lease costs and the other annualized property costs for assets on hand as of January 1, 1985, exclusive of taxes and insurance when paid separately, divided by total patient days in the period June 30, 1983, through July 1, 1984. (10-22-93)

i. Effective July 1, 1989, the property rental rates of leased nursing facilities (NFs) with leases entered into prior to March 30, 1981, may be adjusted to compensate for increased property costs resulting from facility modifications related to major repairs, replacement, expansion, remodeling, or renovation initiated after January 1, 1985, if the cost would be sufficient to reduce the age of the facility by one (1) year or more according to Subsection 060.01.d.i. The rate shall be revised after the completion of such modifications and shall be the greater of the property rental rate previously allowed under Subsection 060.03, or the actual per diem property costs for the amortization, depreciation, and interest not applicable to the modifications for the reporting period in which the modifications were completed, plus the per diem of the first year amortization of the modification expenses using the American Hospital Association guideline useful life of lives. However, no such rate change shall increase the allowable property rental rate by more than three-fourths (3/4) of the difference between the previous rate and the property rental rate that would be allowed for a new building at the time of the proposed rate revision. (10-22-93)

ii. Where such leases contain provisions that bind the lessee to accept an increased rate, reimbursement shall be at a rate per day of care which reflects the increase in the lease rate. (10-22-93)

iii. Where such leases bind the lessee to the lease and allow the rate to be renegotiated, reimbursement shall be at a rate per day of care which reflects an annual increase in the lease rate not to exceed the increase in the consumer price index for renters' costs. After April 1, 1985, if such a lease is terminated or if the lease allows the lessee the option to terminate other than by an option to purchase the facility, the property rental rate shall become the amount "R" determined by the formula in Subsection 060.01 as of the date on which the lease is or could be terminated. (10-22-93)

04. Sale Of A Facility. In the event of the sale of a facility, or asset of a facility, the buyer shall receive the property rental rate of Subsection 060.01, except in the event of a forced sale or except in the event of a first sale of a facility receiving a "grandfathered rate" after June 30, 1991, whereupon the property rental rate of the new owner shall be computed as if no sale had taken place. (10-22-93)

05. Forced Sale Of A Facility. In the event of a forced sale of a facility, or asset of a facility, where the seller has been receiving a grandfathered rate, the buyer will receive a rate based upon his incurred property costs, exclusive of taxes and insurance, for the twelve (12) months following the sale, divided by the facility's total patient days for that period, or the property rental rate, not modified by Section 061, whichever is higher, but not exceeding the rate that would be due the seller. (12-31-91)

061. (RESERVED).

062. PROPERTY REIMBURSEMENT TO INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR CLASS).
Beginning October 1, 1996, property costs of an ICF/MR shall be reimbursed in accordance with Section 060 of these rules except as follows: (7-1-97)

01. Restrictions. No grandfathered rates or lease provisions other than lease provisions in Section 062 of these rules will apply to ICF/MR facilities. (7-1-97)

02. Home Office And Day Treatment Property Costs. Distinct parts of buildings containing ICF/MR living units may be used for home office or day treatment purposes. Reimbursement for the property costs of such distinct parts may be allowed if these areas are used exclusively for home office or day treatment services. The portion of property cost attributed to these areas may be reimbursed as part of home office or day treatment costs without a reduction in the property rental rate. Reimbursement for home office and day treatment property costs shall not include costs reimbursed by, or covered by the property rental rate. Such costs shall only be reimbursed as property cost if the facility clearly included space in excess of space normally used in such facilities. At a minimum to qualify for such reimbursement, a structure would have square feet per licensed bed in excess of the average square feet per licensed bed for other ICF/MR living units within four (4) licensable beds. (7-1-97)

03. Leases For Property. Beginning October 1, 1996, ICF/MR facilities with leases will be reimbursed as follows: (7-1-97)

a. The property costs related to ICF/MR living units other than costs for major movable equipment will be paid by a property rental rate in accordance with Sections 060 and 062 of these rules. (7-1-97)

b. Leases for property other than ICF/MR living units will be allowable based on lease cost to the facility not to exceed a reasonable market rate, subject to other provisions of this chapter, and PRM principles including principles associated with related party leases. (7-1-99)T

063. -- 099. (RESERVED).

100. REASONABLE COST PRINCIPLES.

01. Principle. To be allowable, costs must be reasonable, ordinary, necessary and related to patient care. It will be expected that providers will incur costs in such a manner that economical and efficient delivery of quality health care to beneficiaries will result. (1-16-80)

02. Application. (12-31-91)

a. Reasonable costs of any services are determined in accordance with rules found in Sections 250 through 299 and Provider Reimbursement Manual (PRM), Sections 100 through 2600, as modified by the exceptions contained herein, is used to identify cost items to be included on Idaho's Uniform Cost Report. (7-1-99)T

i. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. (1-16-80)

ii. The objectives of these methods are that: first, the costs with respect to individuals covered by the program will not be borne by others not so covered. Second, the costs with respect to individuals not covered will not be paid by the program. (1-16-80)

b. Costs may vary from one institution to another because of a variety of factors. It is the intent of the program that providers will be reimbursed the actual operating costs of providing high quality care, unless such costs exceed the applicable maximum base rate developed pursuant to provisions of Title 56, Idaho Code, or are unallowable by application of promulgated regulation. (11-4-85)

c. Implicit in the intention that actual operating costs be paid to the extent they are reasonable is the

expectation that the provider seeks to minimize its costs and that its actual operating costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (11-4-85)

d. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable. (1-16-80)

03. Costs Related To Patient Care. These include all necessary and proper costs in developing and maintaining the operation of patient care facilities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expense, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. Example: Depreciation is a method of systematically recognizing the declining utility value of an asset. To the extent that the asset is related to patient care, reasonable, ordinary, and necessary, the related expense is allowable when reimbursed based on property costs according to other provisions of this chapter. Property related expenses are likewise allowable. (12-31-91)

04. Costs Not Related To Patient Care. Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. Example: Fines are imposed for late remittance of federal withholding taxes. Such fines are not related to patient care, are not necessary, and are not reflective of prudent cost conscious management. Therefore, such fines and penalties are not allowable. (1-1-82)

05. Form And Substance. Substance of transactions will prevail over the form. Financial transactions will be disallowed to the extent that the substance of the transaction fails to meet reasonable cost principles or comply with rules and policy. Example: Lease-Purchase agreements are contracts which are executed in the form of a lease. The wording of the contract is couched in such a manner as to give the reader the impression of a true rental-type lease. However, the substance of this contract is a purchase of the property (see Subsection 354.04.c.iii.). If a lease contract is found to be in substance a purchase, the related payments are not allowable as lease or rental expense. (12-31-91)

101. -- 109. (RESERVED).

110. ALLOWABLE COSTS.
Below is a list of the normally allowable costs, and the related definitions and explanations, which includes, but is not limited to, the following items: (7-1-97)

01. Auto And Travel Expense. Expense of maintenance and operation of a vehicle and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement will not exceed the amount determined reasonable by the Internal Revenue Service for the period being reported on. Meal reimbursement will be limited to the amount that would be allowed by the state for a Department employee. Entertainment expense is allowable only if documentation is provided naming the individuals and stating the purpose of the meeting. Entertainment expense is allowable only for patient care related purposes. (7-1-97)

02. Bad Debts. Payments for efforts to collect past due Title XIX accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX coinsurance amounts are one hundred percent (100%) reimbursable (PRM, Section 300). (7-1-99)T

03. Bank And Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable. (1-16-80)

04. Contracted Service. All services which are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility. (1-16-80)

05. Depreciation. Depreciation on buildings and equipment is an allowable property expense for hospital-based facilities. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset. (10-22-93)

06. Employee Benefits. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics. (7-1-99)T

07. Insurance. Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care. (1-16-80)

08. Interest. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable. (7-1-97)

09. Lease Or Rental Payments. Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, shall be reimbursed in the same manner as an owned asset. The cost of leases related to home offices and ICF/MR day treatment services shall not be reported as property costs and shall be allowable based on reasonable cost principles subject to other limitations contained herein. (7-1-97)

10. Payroll Taxes. The employer's portion of payroll taxes is reimbursable. (1-6-80)

11. Property Costs. Property costs related to patient care are allowable subject to other provisions of this chapter. Property taxes and reasonable property insurance are allowable for all facilities. A property rental rate will be paid in lieu of costs in some circumstances according to other provisions of these rules. (7-1-97)

12. Property Insurance. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year. (11-4-85)

13. Repairs And Maintenance. Costs of maintenance and minor repairs are allowable when related to the provision of patient care. (1-16-80)

14. Salaries. Salaries and wages of all employees engaged in patient care activities or overall operation and maintenance of the facility, including support activities of home offices, shall be allowable. (1-16-80)

15. Supplies. Cost of supplies used in patient care or providing services related to patient care are allowable. (1-16-80)

16. Taxes. Property taxes on assets used in rendering patient care are allowable. Other taxes may be allowable. Specifics are covered in the Provider Reimbursement Manual, PRM, Chapter 21. Tax penalties are not allowable. (7-1-99)T

17. Compensation Of Owners. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are actually performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation shall not exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation shall not exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in Sections 402 and 403 of these rules. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following: (7-1-97)

a. Salaries wages, bonuses and benefits which are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period. (7-1-97)

b. Supplies and services provided for the owner's personal use. (1-16-80)

c. Compensation paid by the facility to employees for the sole benefit of the owner. (1-16-80)

d. Fees for consultants, directors, or any other fees paid regardless of the label. (1-16-80)

e. Keyman life insurance. (1-16-80)

f. Living expenses, including those paid for related persons. (1-16-80)

111. -- 114. (RESERVED).

115. NONALLOWABLE COSTS.
In the absence of convincing evidence to the contrary, expenses listed below will be considered nonreimbursable. (1-16-80)

01. Charity Allowances. Cost of free care or discounted services. (1-16-80)

02. Nonpatient Care Related Activities. All activities not related to patient care. (1-16-80)

03. Accelerated Depreciation. Depreciation in excess of straight line except as otherwise provided (see Subsection 354.04.c.ii.). (12-31-91)

04. Related Party Interest. Interest on related party loans (see PRM, Sections 218.1 and 218.2). (7-1-99)T

05. Related Party Nonallowable Costs. All costs not allowable to providers are not allowable to a related party, whether or not they are allocated. (1-16-80)

06. Acquisitions. Cost of corporate acquisitions, e.g., purchase of corporate stock as an investment. (1-16-80)

07. Holding Companies. All home office costs associated with holding companies are not allowable (PRM, Section 2150.2A). (7-1-99)T

08. Related Party Refunds. All refunds, allowances, terms, etc., shall be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc. (1-16-80)

09. Fund Raising. Certain fund raising expenses (PRM, Section 2136.2). (7-1-99)T

10. Vending Machines. Costs of vending machines. Barber and beauty shops. (1-16-80)

11. Organization. Organization costs (see PRM, Section 2134 and subsections of Section 2134 for specifics). (7-1-99)T

12. Fees. Franchise fees (PRM, Section 2133.1). (7-1-99)T

13. Medicare Costs. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services. (7-1-98)

14. Yellow Pages Advertising. Telephone book yellow page advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in. (1-1-82)

15. Consultant Fees. Costs related to the payment of consultant fees in excess of the lowest rate available to a facility. It is the provider's responsibility to make efforts to obtain the lowest rate available to that facility. The efforts may include personally contacting possible consultants and/or advertising. The lowest rate available to a facility is the lower of the actual rate paid by the facility or the lowest rate available to the facility, as determined by departmental inquiry directly to various consultants. Information obtained from consultants will be

provided to facilities. Costs in excess of the lowest rate available will be disallowed effective thirty (30) days after a facility is notified pursuant to Subsection 115.15.b., unless the provider shows by clear and convincing evidence it would have been unable to comply with state and federal standards had the lowest rate consultant been retained or that it tried to but was unable to retain the lowest rate consultant. This Subsection in no way limits the Department's ability to disallow excessive consultant costs under other Sections of this chapter, such as Section 100 or 121, when applicable. (7-1-97)

16. **Goodwill**. Costs associated with goodwill as defined in Subsection 003.27 of these rules. (7-1-97)

17. **Interest**. Interest to finance nonallowable costs. (7-1-97)

18. **Property Costs**. Costs reimbursed based on a property rental rate according to other provisions of these rules. (7-1-97)

116. -- 119. (RESERVED).

120. HOME OFFICE COST PRINCIPLES.
The reasonable cost principles shall extend to the home office costs allocated to individual providers. In addition, the home office, through the provider, shall provide documentation as to the basis used to allocate its costs among the various entities it administers or otherwise directs. (1-1-82)

121. COMPENSATION OF RELATED PERSONS.
Compensation paid to persons related to owners or administrators is allowable only to the extent that services are actually performed and are necessary and adequately documented and the compensation for the services is reasonable. (1-1-82)

01. **Compensation Claimed**. Compensation claimed for reimbursement must be included in compensation reported for tax purposes and be actually paid. (1-1-82)

a. Where such persons perform services without pay, no cost may be imputed. (1-1-82)

b. Time records documenting actual hours worked are required in order that the compensation be allowable for reimbursement. (1-1-82)

c. Compensation for undocumented hours worked will not be a reimbursable cost. (1-1-82)

02. **Related Persons**. A related person is defined as having one (1) of the following relationships with the provider: (1-1-82)

a. Husband or wife; (1-1-82)

b. Son or daughter or a descendent of either; (1-1-82)

c. Brother, sister, stepbrother, stepsister or descendent thereof; (1-1-82)

d. Father, mother, stepfather, stepmother, an ancestor thereof, or a brother or sister thereof; (1-1-82)

e. Son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law; (1-1-82)

f. A descendent of a brother or sister of the provider's father or mother; (1-1-82)

g. Any other person with whom the provider does not have an arms length relationship. (1-1-82)

122. LEGAL CONSULTANT FEES AND LITIGATION COSTS.
Costs of legal consultant fees and litigation costs incurred by the provider will be handled in accordance with the following: (1-1-82)

01. In General. Legal consultant fees unrelated to the preparation for or the taking of an appeal of an audit performed by the Department of Health and Welfare, Office of Audit, or litigation costs incurred by the provider in an action unrelated to litigation with the Department of Health and Welfare will be allowed as a part of the total per diem costs of which the Medicaid Program will reimburse a portion according to the percentage of Medicaid patient days. (1-1-82)

02. Administrative Appeals. In the case of the provider contesting in administrative appeal, the findings of an audit performed by the Department of Health and Welfare, the costs of the provider's legal counsel will be reimbursed by the Medicaid Program only to the extent that the provider prevails on the issues involved. The extent that the provider prevails will be determined based on the ratio of the total dollars at issue for the audit period at issue in the hearing to the total dollars ultimately awarded to the provider for that audit period by the hearing officer or subsequent adjudicator. (10-22-93)

03. Other. All other litigation costs incurred by the provider in actions against the Department of Health and Welfare will not be reimbursable either directly or indirectly by the Medicaid Program except where specifically ordered by a court of law. (1-1-82)

123. OCCUPANCY ADJUSTMENT FACTOR.
In order to equitably allocate fixed costs to the Medicaid patients in cases where a facility is not maintaining reasonable occupancy levels, an adjustment will be made. No occupancy adjustment will be made against property reimbursement paid in lieu of property costs. The adjustment will be made as follows: (11-4-85)

01. Occupancy Levels. If a facility maintains an average occupancy of less than eighty percent (80%) of a facility's capacity, the total property costs will be prorated based upon an eighty percent (80%) occupancy rate. The facility's average occupancy percentage will be subtracted from eighty percent (80%) and the resultant percentage will be taken times the total fixed costs to determine the nonallowable fixed costs. (1-1-82)

02. Occupancy Adjustment. For purposes of an occupancy adjustment, facility capacity will be computed based upon the greater of the largest number of beds for which the facility was licensed during the period being reported on or the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been converted to use for nonroutine nursing home activities or the facility is newly constructed and has entered the Medicaid Program subsequent to January 1, 1982. If the facility's designed capacity has been changed, the number of beds used to determine occupancy will be lowered by the amount of capacity being converted to nonroutine nursing home activities. Facility capacity for a new facility will be based on the number of beds approved by the certificate of need process less any capacity converted to nonroutine nursing home activities. (1-1-82)

03. Fixed Costs. For purposes of an occupancy adjustment fixed costs shall be considered all allowable and reimbursable costs reported under the property cost categories. (11-4-85)

04. Change In Designed Capacity. In cases where a provider changes the designed capacity of a facility, the average occupancy for the period prior to the change and subsequent to the change will be computed and each period will be adjusted separately. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure. (1-1-82)

05. New Facility. In the case of a new facility being licensed and occupied, the first six (6) months occupancy level will not be subject to this adjustment. (1-1-82)

124. RECAPTURE OF DEPRECIATION.
Where depreciable assets that were reimbursed based on cost and were used in the Medicaid Program by a facility subsequent to January 1, 1982, and for which depreciation has been reimbursed by the Program, are sold for an amount in excess of their net book value, depreciation so reimbursed shall be recaptured from the buyer of the facility in an amount equal to reimbursed depreciation after January 1, 1982, or gain on the sale, whichever is less. (9-12-86)

01. Amount Recaptured. Depreciation shall be recaptured in full if a sale of a depreciated facility takes place within the first five (5) years of a seller's ownership. Credit shall be given for the period of ownership prior to January 1, 1982. For every year the asset is held beyond the first five (5) years, the total depreciation recaptured

shall be reduced by ten percent (10%) per year of the total depreciation taken. (1-1-82)

02. Time Frame. Depreciation shall be recaptured by the Medicaid Program from the buyer of the facility over a period of time not to exceed five (5) years from the date of sale, with not less than one-fifth (1/5) of the total amount being recaptured for each year after such date. (1-1-82)

125. -- 149. (RESERVED).

150. RELATED PARTY TRANSACTIONS.

01. Principle. Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership, control, etc., are allowable at the cost to the related party. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. (1-16-80)

02. Cost Allowability - Regulation. Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in 42 CFR 413.17, et al, and the Providers Reimbursement Manual, PRM Chapter 10 and other applicable chapters of the PRM. (7-1-99)T

151. APPLICATION.

01. Determination Of Common Ownership Or Control In The Provider Organization And Supply Organization. In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. (1-16-80)

a. Common Ownership Rule. A determination as to whether an individual(s) possesses ownership or equity in the provider organization and the supplying organization, so that the organizations will be considered to be related by common ownership, will be made on the basis of the facts and circumstances in each case. (1-1-82)

b. Control Rule. The term "control" includes any kind of control whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise (see control definition in Subsection 151.07). (12-31-91)

02. Cost To Related Organizations. The charges to the provider from related organizations may not exceed the billing to the related organization for these services. (1-16-80)

03. Costs Not Related To Patient Care. All home office costs not related to patient care are not allowable under the Program. (1-16-80)

04. Interest Expense. Generally, interest expense on loans between related entities will not be reimbursable. See PRM and Chapters 2, 10 and 12 for specifics. (7-1-99)T

152. EXCEPTION TO THE RELATED ORGANIZATION PRINCIPLE.
An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the intermediary: (1-16-80)

01. Supplying Organization. That the supplying organization is a bona fide separate organization; (1-16-80)

02. Nonexclusive Relationship. That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market. (1-16-80)

153. SALES AND RENTAL OF HOSPITALS OR EXTENDED CARE FACILITIES.
The exception is not applicable to sales, lease or rentals of hospital facilities and nursing homes or extended care facilities. These transactions would not meet the requirement that there be an open, competitive market for the

facilities furnished (PRM, Sections 1008 and 1012). (7-1-99)T

01. Rentals. Rental expense for transactions between related entities will not be recognized. Costs of ownership will be allowed. (1-16-80)

02. Purchases. When a facility is purchased from a related entity, the purchaser's depreciable basis shall not exceed the seller's net book value (PRM, Section 1005). (7-1-99)T

154. INTEREST EXPENSE.
Generally interest on loans between related entities is not an allowable expense. The loan will usually be considered invested capital. See PRM, Chapter 2 for specifics. (7-1-99)T

155. -- 199. (RESERVED).

200. REPORTING SYSTEM.
The objective of the reporting requirements is to provide a uniform system of periodic reports which will allow: (1-16-80)

01. Basis For Reimbursement. A basis of provider reimbursement approximating actual costs. (1-16-80)

02. Disclosure. Adequate financial disclosure. (1-16-80)

03. Statistical Resources. Statistical resources, as a basis for measurement of reasonable cost and comparative analysis. (1-16-80)

04. Criteria. Criteria for evaluating policies and procedures. (1-16-80)

201. PRINCIPLE.
The provider will be required to file mandatory annual cost reports. Additionally, at his option, he may file cost statements more often to meet cash flow requirements. (12-28-89)

202. APPLICATION.

01. Cost Report Requirements. The fiscal year end cost report filing must include: (12-28-89)

a. Annual income statement (two (2) copies); (1-16-80)

b. Balance sheet; (1-16-80)

c. Statement of ownership; (1-16-80)

d. Schedule of patient days; (1-16-80)

e. Schedule of private patient charges; (1-16-80)

f. Statement of additional charges to residents over and above usual monthly rate; and (1-16-80)

g. Other schedules, statements, and documents as requested. (1-16-80)

02. Cost Statement Requirements. Quarterly and short period cost statement filings must include: (12-28-89)

a. Filed not later than sixty (60) days after the close of the period. Reports received after this time will be accepted at the option of the Department. (1-16-80)

b. Statement of current costs to include at least one (1) quarter (or adjusted quarter, if applicable).

Statement may also be filed for any period beginning and ending with quarters of the provider's fiscal year. Other reporting period may be requested. (1-16-80)

c. Schedule of patient days. (1-16-80)

d. Schedule of all patient charges. (1-16-80)

e. Other schedules, statements, and clarifications as requested. (1-16-80)

03. Special Reports. Special reports may be required. Specific instructions will be issued, based upon the circumstance. (1-16-80)

04. Criteria. All reports must meet the following criteria: (1-16-80)

a. State approved formats must be used. (1-16-80)

b. Presented on accrual basis. (1-16-80)

c. Prepared in accordance with generally accepted accounting principles and principles of reimbursement. (1-16-80)

d. Appropriate detail must be provided on supporting schedules or as requested. (1-1-82)

05. Preparer. It is not required that any statement be prepared by an independent, licensed or certified public accountant. (1-16-80)

06. Reporting By Chain Organizations Or Related Party Providers. Section 2141.7, PRM, Providers Reimbursement Manual prohibits the filing of combined or consolidated cost reports as a basis for cost reimbursement. Each facility so related must file a separate set of reports. These cost reports will be required for each level of organization that allocates expenses to the provider. Consolidated financial statements will be considered supplementary information and are not acceptable as fulfilling the primary reporting requirements. (7-1-99)T

07. Change Of Management Or Ownership. To properly pay separate entities or individuals when a change of management or ownership occurs, the following requirements shall be met: (1-16-80)

a. Outgoing management or administration shall file an adjusted-period cost report. This report shall meet the criteria for annual cost reports, except that it shall be filed not later than sixty (60) days after the change in management or ownership. (12-28-89)

b. Incoming managers or owners shall be required to report on the same basis as a new provider (see Section 203). (12-31-91)

c. The Department may require an appraisal at the time of a change in ownership. (9-15-84)

203. REPORTING PERIOD.

When required for establishing rates, new providers will be required to submit three (3) quarterly costs statements, including one (1) adjusted-quarter report (if applicable), before the annual reporting option may be exercised. If a provider enters the program at some point in mid-quarter, his first quarter reporting dates will be adjusted to reflect not less than two (2) months operation nor more than four (4). Thereafter the normal reporting period would apply. If a provider withdraws from the program and subsequently re-enters, the new provider reporting requirements will apply. For purposes of nursing facility rate setting, cost report periods of less than six (6) months will not be used. If a provider changes their fiscal year-end or experiences a change in ownership, the last cost report filed by that facility that is greater than six (6) months will be used until a cost report exceeding six (6) months is received from the new owner, or is based on the new fiscal year. (7-1-99)T

204. FILING DATES.

01. Deadlines. Deadlines for filing quarterly cost statements will be sixty (60) days after the close of the quarter so reported. Deadlines for annual cost reports will be the last day of the third month following the fiscal year end or the deadline imposed by Medicare if the provider is required to file a Medicare cost report. (7-1-97)

02. Waivers. A delay of thirty (30) days may be granted for annual cost reports in unusual circumstances. Requests for such deferrals and reasons therefore must be in writing and should be made prior to the deadline. A written decision will be rendered in writing within ten (10) days. (7-1-97)

205. FAILURE TO FILE.
Failure to submit timely reports may result in a reduction in the interim rate. Failure to file the required cost reports, including required supplemental information, unless a waiver is granted, may result in a reduction of ten percent (10%) in the provider's interim rate(s) the first day of the month following the deadline date. Continued failure to comply will result in complete payment suspension on the first day of the following month. When suspension or reduction has occurred and the provider has filed the required cost reports, amounts accruing to the provider during the period of suspension or reduction will be restored. Loss of license or certification will result in immediate termination of reimbursement, full scope audit and settlement for the cost period. (7-1-97)

206. ACCOUNTING SYSTEM.
Reports must be filed using the accrual basis and conform with generally accepted accounting principles or within provisions of the guidelines as specified. In any case, the recorded transaction must be capable of verification by Departmental audit. (1-16-80)

207. AUDITS.
All financial reports are subject to audit by Departmental representatives (see Sections 350 through 399). (12-31-91)

208. REPORTING FORMS.
Unless prior approval is granted, only state forms will be acceptable. Requests for approval of alternate forms must be in writing accompanied by samples. Such requests will not be considered adequate reason for late filing, or granting of a waiver, except in extraordinary circumstances as determined by the intermediary. Following is a partial listing of the account titles used on the state forms. Included also is an explanation of the classification and reporting standards applicable to that account. The report form may be revised periodically to meet changing Department and provider needs and may be in electronic format at the discretion of the Department. Reported costs shall only include allowable costs unless the Department structures the report to remove nonallowable costs by cost groupings, in which case, reported total and subtotal costs shall reflect net allowable costs except for the nonreimbursable section of the report. (7-1-97)

01. Revenues. The categories are self-explanatory. They are intended to give sufficient breakdown of revenues to effect the reasonable cost principles embodied in the cost reporting system. Facilities may also use the cost center approach of the statement to evaluate the expense of certain cost centers in respect to their revenue. (1-16-80)

02. Expenses. (7-1-93)

a. Administrative. (12-31-91)

i. Salaries: Administrator. Included in this category are salaries paid for administrators and assistant administrators of the facility. Any compensation in excess of the amount allowable under other provisions of this chapter shall be entered in the nonreimbursable Section of the cost statement (see Subsection 110.17 of these rules). (7-1-97)

ii. Salaries: Office and Clerical. Salaries and wages paid to clerks, bookkeepers, and others whose duties relate to overall operation of the facility, should be included in this account. (1-16-80)

iii. Payroll Taxes. The provider's portion of payroll taxes for all employees except those taxes related to the payroll for persons providing day treatment services to ICF/MR patients shall be included in the report categories provided for such costs. Payroll taxes for employees providing day treatment services to ICF/MR patients shall be reported in categories provided for these expenses. Self employment taxes related to owners are nonallowable and

should not be included. (7-1-97)

iv. Employee Benefits. Expenses incurred such as sick pay and vacation pay should be included in this account except for those expenses relating to persons providing day treatment services for ICF/MR patients. Employee benefits for these employees should be reported in cost categories provided for those expenses. (7-1-97)

v. Accounts Collections. The expenses related to collection of past due program accounts such as legal fees, bill collectors, etc., are allowable. Allowances for bad debts and bad debt write-off are not allowable, and should be included in the Section titled Nonreimbursable Expenses. (4-28-89)

vi. Auto and Travel. These expenses shall be those incurred in the operation of vehicles and other travel expense related to patient care. Normally, entertainment shall not be involved, but shall be recorded in the Section under Nonreimbursable Expenses (see PRM, Chapter 21). (7-1-99)T

vii. Bank and Finance Charges. Normally recurring minor charges for handling of accounts shall be included here. (1-16-80)

viii. Dues, Licenses and Subscriptions. Subscriptions to periodicals related to patient care or for general patient use, license fees (not including franchises), and dues to professional health care organizations are to be included. Dues, tuitions and educational fees to facilitate quality health care services are includable where the provisions of PRM, Section 400, are met. (7-1-99)T

ix. Employee Recruitment. Costs of advertising for new employees shall be recorded in this account including applicable entertainment costs. (1-16-80)

x. Home Office Costs. Costs allocated by related entities for various services shall be included in this account. (1-16-80)

xi. Malpractice/Public Liability Insurance. Premiums for malpractice and public liability insurance shall be included in this account. (1-16-80)

xii. Purchased Services. Costs of legal, accounting, and management services (not including related entities) for overall operations shall be included in this account. (1-16-80)

xiii. Supplies and Rentals. Cost of supplies, postage, ledger sheets, and rental of minor office equipment shall be included in this account. (1-16-80)

xiv. Telephone and Communications. Cost of telephone and related communications shall be included in this account. (1-16-80)

xv. Interest, Working Capital. Allowable interest expense for loans not related specifically to the purchase of the real or personal property of the provider shall be reported here. (1-1-82)

xvi. Miscellaneous. Any expense not properly allocable to other cost centers and not properly classified in other classification of administration expenses shall be included here. (1-16-80)

b. Property. Property costs shall be reported by all facilities including those facilities which are reimbursed a property rental rate. (11-4-85)

i. Amortization. Amortization of leasehold improvements shall be included here. Certain others may be included here also. (1-16-80)

ii. Depreciation on Fixed Assets. Depreciation expenses for buildings and fixtures should be included here. Any depreciation in excess of straight line AHA lives shall not be included unless otherwise waived by the Department. Such excess shall be included in the Section of Nonreimbursable Expenses. (7-1-97)

iii. Depreciation of Equipment. Depreciation expense for moveable equipment shall be included here.

Excess depreciation as defined above shall be included in the Nonreimbursable Section (see Subsection 354.04.c.). (12-31-91)

iv. Interest Expense. Interest expense related to purchase of land, buildings and equipment related to patient care shall be included here only if it is payable to unrelated entities. Generally, interest payable to related entities shall be included in the Nonreimbursable Section (PRM, Section 202.3). (7-1-99)T

v. Insurance. Insurance premiums for property insurance such as fire and glass shall be includable here. (1-16-80)

vi. Lease and Rental Payments. Payments for lease or rental of buildings, land and for equipment shall be includable here. (1-16-80)

vii. Taxes. Taxes on property related to patient care shall be recorded in this account. (1-16-80)

c. Patient Care Service. (1-16-80)

i. Nursing Care. (1-16-80)

(1) Salaries. Director of Nursing. Salaries or wages of the Director of Nursing shall be included here. (1-16-80)

(2) Registered Nurse. Salaries and wages of registered nurses shall be included in this account. Payroll taxes shall not be included but overtime shall be. (1-16-80)

(3) Licensed Professional Nurses. Wages for licensed professional nurses shall be included in this account including overtime, but not including payroll taxes. (1-16-80)

(4) Aides/Orderlies. Normal overtime and wages for aides and orderlies, not to include payroll taxes, shall be included in this account. (1-16-80)

(5) Contracted Services. Payments for patient health care services under contract shall be entered here. (1-16-80)

ii. Therapy Services. (1-16-80)

(1) Salaries. Salaries for all therapy personnel shall be recorded here. (1-16-80)

(2) Professional Services. Payments for contracted therapy services shall be recorded here. (1-16-80)

(3) Supplies and Miscellaneous. Expenses for supplies and miscellaneous expenses related to therapy and recreational therapy services shall be recorded here. (1-16-80)

iii. Social Services. (1-16-80)

(1) Salaries. Wages and salaries for activity directors and social services personnel shall be recorded here. (1-16-80)

(2) Contracted Services. Payments under contract arrangement for activities director or other social services personnel shall be included here. (1-16-80)

iv. Payroll Taxes and Employee Benefits. The payroll taxes and cost of employee benefits related to the salaries reported in Section 208 of these rules should be reported here. (7-1-97)

v. Costs Not Subject to the Percentile Cap. (12-31-91)

(1) Special Needs. Those costs determined by the Department and authorized under Section 56-117,

Idaho Code, will be excluded from other reported costs and will be reported here (see Subsection 254.08). (12-31-91)

(2) Excluded Costs. Increases in costs otherwise subject to a cap incurred by facilities as a result of changes in legislation or regulations will be excluded from costs reported in categories subject to the cap and will be reported here (see Subsection 254.09). (7-1-97)

d. Facility Operations and Services. (1-16-80)

i. Central Supply. (1-16-80)

(1) Salaries: Pharmacist. Salaries and wages of pharmacists who are regular employees of the facility shall be included here, but are not reimbursable. (1-16-80)

(2) Salaries. Salaries and wages of others, such as stock clerks, shall be recorded here. (1-16-80)

(3) Contracted Services. Payments for services under contract will be recorded in this category, not including pharmaceutical services. (1-16-80)

(4) Supplies and Miscellaneous. Miscellaneous expenses and routine nursing supplies such as laxatives, aspirin, and dressings shall be recorded here; the cost of oxygen concentrators may also be recorded here. Cost of prescription drugs must not be included. (12-28-89)

ii. Laundry and Linen. (1-16-80)

(1) Salaries. Salaries and wages for personnel involved in laundry operations shall be recorded here. (1-16-80)

(2) Purchased Services. Costs of contracted linen services shall be recorded here. (1-16-80)

(3) Linens and Bedding. Purchase of sheets, mattress pads, blankets, towels, etc., shall be entered here. Costs of beds and mattresses are capitalizable and should be treated accordingly. (1-16-80)

(4) Miscellaneous Expenses. Miscellaneous expenses not properly classified in other areas of Section 208 should be included in this account. (12-31-91)

e. Dietary. (1-16-80)

i. Salaries: Dietitian. Wages of a dietitian who is a regular employee shall be included here. (1-16-80)

ii. Salaries: Other. Salaries of cooks and other dietary personnel should be recorded here. (1-16-80)

iii. Purchased Services. Payments for contracted dietary services, or dietitians, shall be included here. (1-16-80)

iv. Food. Cost of food used for the period will be included here not including vending machine items. For purposes of reasonable cost evaluation, revenues from meals sold to nonpatients will reduce food costs and should be reported in the revenue Section. (1-16-80)

v. Supplies. Cost of dietary supplies other than food should be recorded here. Do not include vending machine items. (1-16-80)

f. Plant Operations and Maintenance. (1-16-80)

i. Salaries. Wages of all housekeeping and maintenance employees shall be included in this account. (1-16-80)

ii. Repairs and Maintenance. Cost of minor repairs to buildings and equipment shall be recorded here.

(1-16-80)

iii. Purchased Services. Costs of maintenance and repair services purchased under contract arrangements shall be recorded here. (1-16-80)

iv. Utilities. Expenses for heat, electricity, water and sewer shall be included in this account. (9-15-84)

v. Supplies and Miscellaneous. Expense of supplies and other unclassified expenses should be included here. (1-16-80)

g. Nonreimbursable Expenses. This classification of expenses is provided to reconcile your cost statement to books of record. It will also help the facility to determine its reasonable costs and anticipate its revenues. Routine business expenses not includable in the reasonable cost formula are to be recorded in Section 208. The account titles are indicative of these costs which are commonly found. (12-31-91)

03. Home Office Reporting. The purpose of the provisions of Section 208, is to support the costs allocated to the provider facility. A report is required for each level of organization which allocates costs to the provider, directly or indirectly. (7-1-97)

209. -- 239. (RESERVED).

240. PROSPECTIVE RATES FOR ICF/MR.
Sections 240 through 247 of these rules provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the payment system for ICF/MR providers. Total payment will include the following components: Property reimbursement, capped costs, an efficiency increment, exempt costs, excluded costs. (7-1-99)T

241. PRINCIPLE.
Providers of ICF/MR facilities will be paid a per diem rate which, with certain exceptions, is not subject to an audit settlement. The per diem rate for a fiscal period will be based on audited historical costs adjusted for inflation. The provider will report these cost items in accordance with other provisions of this chapter or the applicable provisions of PRM to the extent not inconsistent with this chapter. (7-1-99)T

242. PROPERTY REIMBURSEMENT.
Beginning October 1, 1996, ICF/MR property costs are reimbursed by a rental rate or based on cost. The following shall be reimbursed based on cost as determined by the provisions of this chapter and applicable provisions of PRM to the extent not inconsistent with this chapter: ICF/MR living unit property taxes, ICF/MR living unit property insurance, and major movable equipment not related to home office or day treatment services. Reimbursement of other property costs is included in the property rental rate. Any property cost related to home offices and day treatment services are not considered property costs and shall not be reported in the property cost portion of the cost report. These costs shall be reported in the home office and day treatment section of the cost report. Property costs, including costs which are reimbursed based on a rental rate, shall be reported in the property cost portion of the cost report. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. Property costs include the following components: (7-1-99)T

01. Depreciation. Allowable depreciation based on straight line depreciation. (7-1-97)

02. Interest. All allowable interest expense which relates to financing depreciable assets. Interest on working capital loans is not a property cost and is subject to the cap. (7-1-97)

03. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances are not property costs. (7-1-97)

04. Lease Payments. All allowable lease or rental payments. (7-1-97)

05. Property Taxes. All allowable property taxes. (7-1-97)

06. Costs Of Related Party Leases. Costs of related party leases are to be reported in the property cost categories based on the owner's costs. (7-1-97)

243. ICF/MR CAPPED COST.
Beginning October 1, 1996, this cost area includes all allowable costs except those specifically identified as property costs in Section 242 and exempt costs or excluded costs in Section 246 or 247 of these rules. This Section defines items and procedures to be followed in determining this limit and provides the procedures for extracting cost data from historical cost reports, applying a cost forecasting market basket to project cost forward, procedures to be followed to project costs forward, and procedures for computing the median of the range of costs and the ICF/MR cap. (7-1-97)

01. Costs Subject To The Cap. Items subject to the cap include all allowable costs except property costs identified in Section 242 and exempt costs or excluded costs identified in Section 246 or 247 of these rules. Property costs related to a home office are administrative costs, shall not be reported as property costs, and are subject to the cap. (7-1-97)

02. Per Diem Costs. Costs to be included in this category will be divided by the total patient days for the facility for the cost reporting period to arrive at allowable per diem costs. If costs for services provided some or all non-Medicaid residents are not included in the total costs submitted, the provider must determine the costs and combine them with the submitted costs in order that a total per diem cost for that facility can be determined both for the purpose of determining the ICF/MR cap and for computing final reimbursement. (7-1-97)

03. Cost Data To Determine The Cap. Cost data to be used to determine the cap for ICF/MR facilities will be taken from each provider's most recent final cost report available sixty (60) days before the beginning of the period for which the cap is being set. Cost reports are final when the final audit report is issued, or earlier if the Department informs the facility the report is final for rate setting purposes. The selected final cost report will be used to establish the facility's prospective reimbursement rate. However, the final cost reports covering a period of less than twelve (12) months will be included in the data for determining the cap at the option of the Department. (7-1-97)

04. Projection. Per diem allowable costs will be inflated forward using a cost forecasting market basket and forecasting indices according to the same table as used for free standing facilities in Subsection 254.04.a. of these rules. (7-1-97)

a. The projection method used in this Section to set the cap will also be used to set non property portions of the prospective rate which are not subject to the cap. (7-1-97)

b. Forecasting indices as developed by Data Resources, Incorporated, will be used unless they are unavailable. In such case, indices supplied by some other nationally recognized forecaster will be used. (7-1-97)

05. Costs Which Can Be Paid Directly By The Department To Non ICF/MR Providers. Costs which can be paid directly by the Department to non ICF/MR providers are excluded from the ICF/MR prospective rates and ICF/MR cap: (7-1-97)

a. Direct physician care costs. Physicians who provide these services must bill the Medicaid program directly using their own provider numbers. (7-1-97)

b. Costs of services covered under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) portion of the Medicaid Program. These services are enumerated in IDAPA 16 Title 03, Chapter 09, "Rules Governing Medical Assistance," and include such items and services as eyeglasses, hearing aids, and dental services provided to Medicaid recipients under the age of twenty-one (21). The cost of these services is not includable as a part of ICF/MR costs. Reimbursement can be made to a professional providing these services through his billing the Medicaid Program on his own provider number. (7-1-97)

c. Costs of services covered by other parts of the Medicaid Program. Examples of these items include legend drugs and ambulance transportation. These items must be billed to the Medicaid Program directly by the provider using his own provider number. (7-1-97)

06. Cost Projection. Allowable per diem costs will be projected forward from the midpoint of the Base Period to the midpoint of the Target Period. "Base Period" is defined as the last available final cost report period. "Target Period" is defined as the effective period of the prospective rate. Procedures for inflating these costs are as follows: (7-1-97)

a. The percentage change for each cost category in the market basket will be computed from the beginning to the end of the Base Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward allowable per diem costs for each cost category from the midpoint to the end of the Base Period. (7-1-97)

b. The percentage change for each cost category in the market basket will be computed for the period from the end of the Base Period to the beginning of the Target Period. These percentages will then be used to project forward the allowable per diem costs for each cost category, as determined in Subsection 243.06.a. of these rules, from the end of the Base Period to the beginning of the Target Period. (7-1-97)

c. The percentage change for each cost category in the market basket will be computed for the beginning to the end of the Target Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward the allowable per diem costs as determined in Subsection 243.06.b. of these rules from the beginning to the midpoint of the Target Period. (7-1-97)

07. Cost Ranking. Prior to October 1 of each year the Director will determine that percent above the median which will assure aggregate payments to ICF/MR providers will approximate but not exceed amounts that would be incurred using Medicare cost principles of reimbursement. That percentage will apply to caps and rates set after September 30 of each year. Projected per diem costs as determined in this Section and subject to the cap will be ranked from the highest to the lowest. The cap will be set at a percent of the bed-weighted median for each rate period. The initial cap will be set as of October 1, 1996. (7-1-97)

a. The median of the range will be computed based on the available data points being considered as the total population of data points. (7-1-97)

b. The cap for each ICF/MR facility with a fiscal year beginning October 1, 1996, will be computed prior to the beginning of that year. For those facilities with a fiscal year ending on a date other than September 30, the first cap will be computed for the period beginning October 1, 1996, and ending on the fiscal year end date. (7-1-97)

c. Facilities with cost reports that transcend the period from October 1, 1996, through September 30, 1997, will be retrospectively settled using the previous reimbursement system for the period of the report up to September 30, 1996. There will not be a retrospective settlement on the portion of these cost reports attributed to October 1, 1996 through the end of the cost report period unless provisions of Section 245 of these rules apply. (7-1-97)

d. Cost reports for periods beginning on or after October 1, 1996, will not be subject to retrospective settlement except as required by other provisions of this chapter. (7-1-97)

e. A new cap and rate will be set for each facility's fiscal year after September 30, 1996. (7-1-97)

f. The cap and prospective rate will be determined and set for each facility's upcoming fiscal year prior to that year and it will not be changed by any subsequent events or information with the exception that if the computations were found to contain mathematical or clerical errors, these errors will be corrected and the cap will be adjusted using the corrected figures. (7-1-97)

g. Payment of costs subject to the cap will be limited to the cap unless the Department determines the exclusions found in Section 247 of these rules apply. (7-1-97)

h. A facility which commences to offer patient care services as an ICF/MR on or after October 1, 1996, shall be subject to retrospective settlement until the first prospective rate is set. Such facility shall be subject to the ICF/MR cap as determined in this chapter. The first prospective rate for this provider will be set by the Department based on quarterly cost statements and final cost reports submitted for periods following the first three (3)

months of operation. This first prospective rate may be set after the beginning of the second fiscal year of the provider. For the second year the provider will be paid a rate to be settled retrospectively unless both the Department and the provider agree to a prospective rate or rates covering that fiscal period. (7-1-97)

244. EFFICIENCY INCREMENT FOR ICF/MR.
An efficiency increment will be included as a component of the prospective rate, or retrospective settlement if the allowable capped per diem costs are less than the cap. (7-1-99)T

01. Computing Efficiency Increment. The efficiency increment will be computed by subtracting the projected or, for facilities subject to retrospective settlement the actual allowable per diem costs incurred by the provider, from the applicable cap. This difference will be divided by five (5). The allowable increment is twenty cents ($.20) per one dollar ($1) below the cap up to a maximum increment of three dollars ($3) per patient day. (7-1-97)

02. Determining Reimbursement. Total reimbursement determined by adding amounts determined to be allowable, shall not exceed the provider's usual and customary charges for these services as computed in accordance with this chapter and PRM. In computing patient days for the purpose of determining per diem costs, in those cases where the Medicaid Program or the patient is making payment for holding a bed in the facility, the patient will not be considered to be discharged and thus those days will be counted in the total. (7-1-99)T

245. RETROSPECTIVE SETTLEMENT.
When retrospective settlement is applicable, it is based on allowable reimbursement in accordance with this chapter and based on an audit report. Retrospective settlement will be subject to the same caps and limits determined for prospective payments. (7-1-97)

01. A Provider's Failure To Meet Any Of The Conditions. A provider's failure to meet any of the conditions of participation set forth in 42 CFR 483, Subpart I, may subject that provider to retrospective reimbursement for the fiscal year, or any portion thereof, during which the condition is not met. The provider's projected per diem rate may be adjusted to reflect actual reimbursable costs subject to cost limits. (7-1-97)

02. A First Time Provider. A first time provider operating a new ICF/MR living unit will be subject to a retrospective settlement for the first fiscal year and until the first subsequent period wherein a prospective rate is set in accordance with Sections 203, 204, and 243 and this chapter. A budget based on the best available information is required prior to opening for patient care so an interim rate can be set. (7-1-97)

03. New ICF/MR Living Unit. A new ICF/MR living unit for an existing operator is subject to first time facility requirements if the new living unit reflects a net increase in licensed beds, otherwise the Department may set a prospective rate with the nonproperty rate components based on similar components of rates most recently paid for the patients moving into the facility. The property rental rate will be set according to applicable provisions of this chapter. (7-1-97)

04. Change Of Ownership Of Existing ICF/MR Living Unit. Where there is a change of ownership of an existing ICF/MR living unit, the provider operating the ICF/MR living unit will not receive an adjustment of the provider's prospective rate except that the property rental portion of the rate will be adjusted subject to property rental provisions of this chapter. However, new facility reporting requirements and the cap will apply. (7-1-97)

05. Fraudulent Or False Claims. Providers who have made fraudulent or false claims are subject to retrospective settlement as determined by the Department. (7-1-97)

06. Excluded Costs. Excluded costs may be retrospectively settled according to the provisions of Section 247 of these rules. (7-1-97)

246. EXEMPT COSTS.
Exempt costs are not subject to the ICF/MR cap. (7-1-97)

01. Day Treatment Services. As specified in this Section, the cost of day treatment services may be reimbursed in this category and may not be subject to the ICF/MR cap. (7-1-97)

a. This category includes the direct costs of labor, benefits, contracted services, property, utilities and supplies for such services up to the limitations provided in this Subsection. (7-1-97)

b. When a school or another agency or entity is responsible for or pays for services provided to a patient regularly during normal working hours on weekdays, no costs will be assigned to this category for such services. The Department will not reimburse for the cost of services which are paid for or should be paid for by an other agency. (7-1-97)

c. When ICF/MR day treatment services are performed for patients in a licensed Developmental Disability Center, the allowable cost of such services shall be included in this category, but not more than the amount that would be paid according to the Department's fee schedule for individual or group therapy for similar services. Amounts incurred or paid by the ICF/MR in excess of what would be paid according to the Department's fee schedule for like services are not allowable costs and shall be reported as nonreimbursable. (7-1-97)

d. For day treatment services provided in a location other than a licensed developmental disability center, the maximum amount reportable in this category shall also be limited. Total costs for such services reported by each provider in this category shall be limited to the number of hours, up to thirty (30) hours per week per client, of individual or group developmental therapy times the hourly rate that would be paid according to the most recent Department fee schedule for the same services if provided in a developmental disability center. Costs in excess of the limits determined in this Subsection shall be classified and reported as subject to the ICF/MR cap. Initial rates established under the prospective system effective October 1, 1996, and not later than October 1, 1997, will not include a limitation of day treatment costs based on the hourly rate, when the hours of individual or group therapy were not obtained or audited by the Department at the time the rate was published. However, if a provider believes that the day treatment cost used to establish the day treatment portion of its prospective rate was misstated for rates set for periods beginning October 1, 1996, through rates beginning October 1, 1997, revisions to the prospective rate may be made to the extent the provider demonstrates, to the satisfaction of the Department, that the cost used was misstated. Such a revision will be considered only if the provider requests a revision and provides adequate documentation within sixty (60) days of the date the rate was set. At the option of the Department it may negotiate fixed rates for these day treatment services. Such rates shall be set so the aggregate related payments are lower than would be paid with a limitation based on schedules used for licensed Developmental Disability Centers. (7-1-97)

e. Financial data including expenses and labor hours incurred by or on behalf of the provider in providing day treatment services, must be identifiable and separate from the costs of other facility operations. Reasonable property costs related to day treatment services and not included in the property rental rate, shall be separately identified, shall be reported as day treatment services costs, and shall not include property costs otherwise reimbursed. Property costs related to day treatment services shall be separately identified as not related to living unit costs by a final audit determination issued prior to October 1, 1996, or shall be separate and distinct from any property used for ICF/MR services which are or were day treatment services. (7-1-97)

f. In the event a provider has a change in the number of patients requiring day treatment services, the prospective rate may be adjusted by the Department to reflect a change in costs related to such a change. Providers receiving such changes may be required to provide added documentation to the Department to assure that further changes can be identified and the prospective rate adjusted accordingly. (7-1-97)

02. Major Movable Equipment. Costs related to major movable equipment, as defined in this chapter shall be exempt from the ICF/MR cap and shall be reimbursed prospectively based on Medicare principles of cost reimbursement. (7-1-97)

247. COSTS EXCLUDED FROM THE CAP.

Certain costs may be excluded from the ICF/MR cap, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective rate as provided in this Section to assure equitable reimbursement: (7-1-97)

01. Increases Of More Than One Dollar Per Patient Day In Costs. Increases of more than one dollar ($1) per patient day in costs otherwise subject to the cap incurred by a facility as a result of changes in State or Federal laws or rules will be reported separately on the cost report for reports filed less than thirty (30) months, or a greater length of time if so directed by the Department, from the date such increases were first required. Such costs

will be subdivided into the component parts of wages, benefits, contracted services and other costs in the amounts equal to costs removed from the respective cost categories subject to the cap. The Department may adjust the forecasted rate to include the projected per diem related to such costs. (7-1-97)

a. The provider shall report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. (7-1-97)

b. If more than one (1) increase occurs as a result of one (1) or more law or rule change, the costs from each event are to be reported separately. (7-1-97)

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. (7-1-97)

d. For interim rate purposes the provider's prospective rate may be granted an increase to cover such cost increases. A cost statement covering a recent period may be required with the justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled. (7-1-97)

e. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at it's option, include all of the previously excluded costs related to those increases with costs subject to the cap when setting rates or increase the cap and individual facility prospective rates following such cost increases. If a cap is set with these particular costs included in the cap category, providers subject to that cap will not have these costs excluded from the cap for prospective rate purposes. The intent of this provision is for costs to be exempt from the cap until these costs are able to be fully and equitably incorporated in the data base used to project the cap and for these costs to be exempt only when they are not included in the data base. In those cases, when costs are not incurred immediately after a change in rule or law, delays in incorporating the new costs in the cap are warranted. (7-1-97)

f. When cost increases which have been excluded from the cap are incorporated in the inflation indices used to set the cap, the cost indices will be adjusted to exclude the influence of such changes if the amount is included in the index is identified. When the cap is set to include previously excluded amounts, any adjustments previously made to the indexes related to the previously excluded costs will be removed. (7-1-97)

02. Excess Inflation. Reimbursement of costs subject to the cap will be limited to the cap unless the Department determines the inflation indices used to set the prospective rates for a reporting period understated actual inflation by more than seven (7%) percentage points. In such case, prospective rates and the cap will be increased by the amount which actual inflation indices exceeded projected inflation indices and may be retrospectively adjusted by the department. (7-1-97)

03. Cost Increases Greater Than Three Percent. Cost increases greater than three percent (3%) of the projected interim rate which result from disasters such as fire, flood, or earthquake, epidemic or similar unusual and unpredictable circumstances over which a provider has no control. In such case, prospective rates will be increased and will not be subject to the cap, by the amount which actual inflation indices exceeded projected inflation indices and may be retrospectively adjusted by the Department for purposes of this Subsection, disaster does not include personal or financial problems. (7-1-97)

04. Decreases. In the event of state or federal law, rule, or Policy changes which result in clearly identifiable reductions in required services, the Department may reduce the prospective rate to reflect the identified per diem amount related to such reductions. (7-1-97)

05. Prospective Negotiated Rates. Notwithstanding the provisions of Sections 240 through 246, the Director shall have the authority to negotiate prospective rates for providers who would otherwise be subject to accept retrospective settlement. Such rates shall not exceed the projected allowable rate that would otherwise be reimbursed based on provisions of this chapter. (7-1-97)

248. SPECIAL RATES FOR ICF'S/MR.
In accordance with Section 56-117, Idaho Code, the Director may pay facilities a special rate for care given to consumers who have long-term care needs beyond the normal scope of facility services. These individuals must have

needs which are not adequately reflected in the rates calculated pursuant to the principles set in Section 56-113, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of Section 248, will be excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, and IDAPA 16.03.10, "Rues Governing Medicaid Provider Reimbursement". (2-15-00)T

01. Determinations. A determination to approve or not approve a special rate will be made on a consumer-by-consumer basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. (2-15-00)T

02. Approval. Authorization of a special rate is required prior to admission. In an emergency situation if necessary to divert the consumer from a more restrictive placement, prior authorization is not required for up to seventy-two (72) hours. An emergency situation constitutes a diversion from a more restrictive placement. (2-15-00)T

03. Reporting. Costs equivalent to payments at the special rate will be removed from the cost components subject to limits, and will be reported separately. (2-15-00)T

04. Limitations. The reimbursement rate paid will not exceed the provider's charges to other patients for similar services. (2-15-00)T

249. (RESERVED).

250. COST LIMITS FOR NURSING FACILITIES.
Sections 250 through 312 of these rules, provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the nursing home reimbursement system as specified in Sections 56-101 through 56-135, Idaho Code. All audits related to fiscal years ending on or before December 31, 1999 are subject to rules in effect before July 1, 1999. (7-1-99)T

251. PRINCIPLE.
Providers of nursing home services will be paid at the allowed amount determined in accordance with Section 56-101 to 56-131, Idaho Code. Total payment will be made up of the total of the following components: (7-1-99)T

01. Property And Utility Costs. All allowable property and utility costs; (9-15-84)

02. Nonproperty, Nonutility Costs. Nonproperty nonutility costs as determined in accordance with the above mentioned Sections of the Idaho Code. (9-15-84)

03. Efficiency Increment. An efficiency increment determined in accordance with the above mentioned Sections of the Idaho Code. (1-1-82)

04. Exempt Costs. Other allowable costs exempt from the percentile cap under Sections 56-110(b) and 56-117, Idaho Code, as specified in Subsection 254.08 and 254.09. (12-31-91)

252. PROPERTY AND UTILITY COSTS.
The allowability of each of these cost items will be determined in accordance with other provisions of this chapter, or the PRM in those cases where this the rules of this chapter are silent or not contradictory. Total property and utility costs are defined as being made up of the following cost categories. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. (7-1-99)T

01. Depreciation. All allowable depreciation expense. (1-1-82)

02. Interest. All allowable interest expense relating to financing building and equipment purchases. Interest on working capital loans will be included as administrative costs. (1-1-82)

03. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances will not be considered to be property costs. (1-1-82)

04. Lease Payments. All allowable lease or rental payments. (1-1-82)

05. Property Taxes. All allowable property taxes. (1-1-82)

06. Utility Costs. All allowable expenses for heat, electricity, water and sewer. (9-15-84)

253. -- 299. (RESERVED).

300. RATE SETTING.
The objectives of the rate setting mechanism for nursing facilities are: (7-1-97)

01. Payments. To make payments to nursing facilities through a prospective cost-based system which includes facility-specific case mix adjustments. (7-1-99)T

02. Rate Adjustment. To set rates based on each facility's case mix index on a quarterly basis and establishing rates that reflect the case mix of that facility's Medicaid residents as of a certain date during the preceding quarter. (7-1-99)T

301. PRINCIPLE.
Reimbursement rates will be set based on projected cost data from cost reports and audit reports. Reimbursement is to be set for freestanding and hospital-based facilities. In general, the methodology will be a cost-based prospective reimbursement system with an acuity adjustment for direct care costs. (7-1-99)T

302. DEVELOPMENT OF THE RATE.
Rates shall be rebased annually. Rate setting shall be prospective with new rates effective July 1 of each year. There will be no settlement between actual costs incurred during the rate year and the rate itself. Rates for skilled care nursing facilities with unaudited cost reports will be interim rates established by the Department until a rate is calculated based on an audited cost report. The draft audit of a cost report submitted by a facility shall be issued by the Department no later than five (5) months from the date all information required for completion of the audit is filed with the Department. Data used to develop the reimbursement rate for nursing facilities will be made up of the following components: (7-1-99)T

01. Property Reimbursement. Per diem property costs as shown on the latest twelve (12) month cost report or audit report whichever is to be used in accordance with the cost reporting standards specified in Subsections 254.03.a. and 254.03.b. and the property rental rate as determined by Section 060, for facilities which receive this rate in lieu of property costs. No inflationary increase will be considered for property costs for the purpose of developing the interim rate. The property reimbursement component will be calculated in accordance with Section 060 of these rules. (7-1-99)T

02. Utility Costs. Projected utility costs for the facility's upcoming fiscal year may be submitted to the Department not less than ninety (90) days prior to the beginning date of the facility's upcoming fiscal year. In the absence of such submission the Department will project the facility's utility costs utilizing the methodologies found in Subsection 254.06. (12-31-91)

03. Direct Care Component. The direct care component of a facility's rate is the lesser of the facility's inflated direct care per diem costs, or the case mix adjusted per diem cost limit for that type of provider (free-standing nursing facility and urban hospital-based facilities, or rural hospital-based facilities). The lesser of the cost or limitation is then case mix adjusted, based on the facility's Medicaid case mix index. (7-1-99)T

a. All costs included in the direct care component will be adjusted based on the facility's case mix indices, with the exception of raw food and Medicaid related ancillary costs. (7-1-99)T

b. The direct care limitation will be adjusted based on each facility's case mix index. The calculated direct care limit will be divided by the statewide average facility-wide case mix index, and then multiplied by the

individual facility-wide case mix index. (7-1-99)T

c. The lesser of the cost or limit will be divided by the facility-wide case mix index, and then multiplied by the most recent quarterly Medicaid case mix index to arrive at the direct care component. (7-1-99)T

04. Indirect Care Component. The indirect care component of a facility's rate is the lesser of the facility's inflated indirect care per diem costs, or the indirect per diem cost limit for that type of provider (freestanding nursing facilities and urban hospital-based facilities, or rural hospital-based facilities). (7-1-99)T

05. Efficiency Incentive. The efficiency incentive is available to those providers, both freestanding and hospital-based, which have inflated per diem indirect care costs less than the indirect per diem cost limit for that type of provider. The efficiency incentive is calculated by multiplying the difference between the per diem indirect cost limit and the facility's inflated per diem indirect care costs by seventy percent (70%). There is no incentive available to those facilities with per diem costs in excess of the indirect care limit, or to any facility based on the direct care component. (7-1-99)T

06. Calculated Reimbursement Rate. The reimbursement rate for a facility will be the sum of the Direct Care Component, Indirect Care Component, Efficiency Incentive, Cost Exempt from Limitation, and Property Reimbursement. In no case will the interim reimbursement rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is being made as computed by the lower of costs or customary charges. (7-1-99)T

07. Cost Component. The cost component of each facility's rate shall be established effective July 1 of each year and remain in effect through the following June 30. The cost data used in establishing the cost component of the rate calculation will be from the audited or unaudited cost report which ended during the previous calendar year (i.e., cost reports ending during the period from January 1, 1998 - December 31, 1998 will be used in setting rates effective July 1, 1999). If unaudited data is used, the rate will be considered an interim rate until the audited data is available, at which time a retroactive adjustment to the payment rate will be made. (7-1-99)T

08. Case Mix Component. The Medicaid case mix indices used in establishing each facility's rate will be recalculated quarterly and each facility's rate will be adjusted accordingly. The case mix indices will be calculated based on the most recent assessment for each resident in the facility on the first day of the first month of the preceding quarter (i.e., assessments as of April 1, 1999 would be used to establish the case mix indices needed to establish rates for the quarter beginning July 1, 1999. (7-1-99)T

303. COST LIMITS.

Effective July 1, 1999, and each July 1 thereafter, cost limitations shall be established for nursing facilities based on the most recent audited cost report with an end date of June 30 of the previous year or before. Calculated limitations shall be effective for a one (1) year period, from July 1 through June 30 of each year. (7-1-99)T

01. Percentage Above Bed-Weighted Median. Prior to establishing the first "shadow rates" at July 1, 1999, the estimated Medicaid payments under the previous retrospective system for the year period from July 1, 1999 through June 30, 2000 will be calculated. This amount will then be used to model the estimated payments under the case mix system set forth in Sections 300 through 302 of these rules. The percentages above the bed-weighted median, for direct and indirect costs, will be established at a level that approximates the same amount of Medicaid expenditures as would have been produced by the retrospective system. The percentages will also be established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the retrospective system. Once the percentage is established, it will be used to calculate the limit by multiplying the bed-weighted median per diem direct cost times the calculated percentage for that class of provider. There will be a direct and indirect percentage that is applied to freestanding and urban hospital-based nursing facilities, and a higher direct and indirect percentage that is applied to rural hospital-based nursing facilities. Once established, these percentages will remain in effect for future rate setting periods. (7-1-99)T

02. Direct Cost Limits. The direct cost limitation shall be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be normalized and arrayed from high to low, with freestanding and hospital-based nursing facilities included in the same array, and the bed-weighted median will

be computed. (7-1-99)T

03. Indirect Cost Limits. The indirect cost limitation shall be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with freestanding and hospital-based nursing facilities included in the same array, and the bed-weighted median will be computed. (7-1-99)T

04. Limitation On Increase Or Decrease Of Cost Limits. Increases in the direct and indirect cost limits shall be determined by the limitations calculated effective July 1, 1999, indexed forward each year by the inflation factor plus two percent (2%) per annum. Furthermore, the calculated direct and indirect cost limits shall not be allowed to decrease below the established limitations effective July 1, 1999. The maximum rate of growth on the cost limits, and the minimum cost limitation, will be examined by the oversight committee after a three-year period to determine which factors to use in the calculation of the limitations effective July 1, 2002 and forward. (7-1-99)T

05. Costs Exempt From Limitations. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in Section 123. (7-1-99)T

304. TREATMENT OF NEW BEDS.
Facilities which add beds subsequent to the effective date of these rules (July 1, 1999), will have their reimbursement rate subjected to an additional limitation for the next three (3) full years. This limitation will apply beginning with the first rate setting period which utilizes a cost report that includes the date when the beds were added. The facility's rate will be limited to the bed-weighted average of two (2) rates. Those two (2) rates are: (7-1-99)T

01. Limitation Of Facilities Rate. The facility's rate will be limited to the bed-weighted average of the facility's rate calculated in accordance with Section 302, and the current median rate for skilled care facilities of that type (freestanding or hospital-based) established each July 1. (7-1-99)T

02. Calculation Of New Bed Rate. The current calculated facility rate will be multiplied by the number of beds in existence prior to the addition. The median rate will be multiplied by the number of added beds (weighted for the number of days in the cost reporting period for which they were in service). These two (2) amounts will be added together and divided by the total number of beds (with the new beds being weighted if they were only in service for a portion of the year). The resulting per diem will represent an overall limitation on the facility's reimbursement rate. Providers with calculated rates that do not exceed the limitation will receive their calculated rate. (7-1-99)T

03. Exception To New Bed Rate. The following situations will not be treated as new beds for reimbursement purposes: (7-1-99)T

a. Any beds converted from nursing facility to assisted living beds may not be reclassified to new nursing facility beds until three (3) years have elapsed from the date the beds were reclassified to assisted living beds. (7-1-99)T

b. Beds which are added as a result of expansion plans which the Department was made aware of in writing prior to July 1, 1999. The facility must have already expended significant resources on the purchase of land, site planning, site utility planning and/or development. Simply the existence of adequate land and/or space will not constitute having expended significant resources for the purposes of expansion. A written request with adequate supporting documentation for an exception under this provision must be received by the Department no later than December 31, 1999. In no case will beds added subsequent to July 1, 2003 qualify for the exception to the new bed criteria. (7-1-99)T

c. Beds which are decertified as a requirement of survey and certification due to deficiencies at the facility may be re-certified as existing beds with the approval of the Department. (7-1-99)T

305. TREATMENT OF NEW FACILITIES.
Facilities constructed subsequent to July 1, 1999, will be reimbursed at the median rate for skilled care facilities of

that type (freestanding or hospital-based) for the first three (3) full years of operation. During the period of limitation, the facility's rate will be modified each July 1 to reflect the current median rate for skilled care facilities of that type. After the first three (3) full years, the facility will have its rate established at the next July 1 with the existing facilities in accordance with Section 302 of this rule. (7-1-99)T

306. TREATMENT OF A CHANGE IN OWNERSHIP.
New providers resulting from a change in ownership of an existing facility shall receive the previous owner's rate until such time as the new owner has a cost report which qualifies for the rate setting criteria established under these rules. (7-1-99)T

307. DISTRESSED FACILITY.
If the Department determines that a facility is operationally or financially unstable, is located in an under-served area, or addresses an under-served need, the Department may negotiate a reimbursement rate different than the rate then in effect for that facility. (7-1-99)T

308. INTERIM ADJUSTMENTS TO RATES AS A RESULT OF NEW MANDATES.
Certain costs may be excluded from the cost limit calculations, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective rates as provided in this Section to assure equitable reimbursement: (7-1-99)T

01. Changes Of More Than Fifty Cents Per Patient Day In Costs. Changes of more than fifty cents ($.50) per patient day in costs otherwise subject to the cost limitations incurred by a facility as a result of changes in state or federal laws or rules will be reported separately on the cost report until such time as they can be properly reflected in the cost limits. (7-1-99)T

a The provider shall report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. These costs will be reported separately and will not be reimbursed through the rate setting process until the costs are fully represented in the cost data used to establish the cost limitations and rates. (7-1-99)T

b. If more than one (1) increase occurs as a result of one (1) or more law or rule changes, the costs from each event are to be reported separately. (7-1-99)T

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. (7-1-99)T

02. Interim Rate Adjustments. For interim rate purposes, the provider may be granted an increase in its prospective rate to cover such cost increases. A cost statement covering a recent period may be required with justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled. (7-1-99)T

03. Future Treatment Of Costs. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at it's option, include all of the previously excluded costs related to those increases in the calculation of costs subject to the cost center limits. The intent of this provision is for costs to be exempt from the cost limits until these costs are able to be fully and equitably incorporated into the data base used to project the cost limits. When cost increases which have been excluded from the cap are incorporated in the inflation indices used to set the cost limits, the cost indices will be adjusted to exclude the influence of such changes if the amount included in the index is identified. When the cost limits are set to include previously excluded amounts, any adjustments made to the indices related to the previously excluded costs will be removed. (7-1-99)T

309. MDS REVIEWS.
The following Minimum Data Set reviews will be conducted: (7-1-99)T

01. Facility Review. Subsequent to the picture date, each facility will be sent a copy of its resident roster (a listing of residents, their RUG classification, case mix index, and identification as Medicaid or other). It will be the facility's responsibility at that time to review the roster for accuracy. If the roster is accurate, the facility will

sign and return the roster for rate setting. If any errors are detected, those errors will be communicated to the Department in writing along with any supporting documentation. If the signed resident roster is not returned and no errors are communicated to the Department, the original resident roster will be used for rate setting. Once the resident roster has been used for rate setting, it will be considered final unless modified by subsequent Departmental review. (7-1-99)T

02. Departmental Review. If a departmental review of the MDS data reveals errors that result in an incorrect case mix index, the provider's rate will be retroactively adjusted, for all quarters containing the incorrect assessment, and an amount due to or from the Department will be calculated. This does not include residents who received the default classification due to incomplete or inconsistent MDS data. (7-1-99)T

310. SPECIAL RATES.
Section 56-117, Idaho Code, provides authority for the Director to pay facilities a special rate for care given to patients who have long term care needs beyond the normal scope of facility services. These patients must have needs which are not adequately reflected in the rates calculated pursuant to the principles set forth in Section 56-102, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of this section will be excluded from the computation of payments or rates under other provisions of Section 56-102, Idaho Code, and these rules. (7-1-99)T

01. Determinations. A determination to approve or not approve a special rate will be made on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request will be for an expected condition that will be on-going for a period of greater than two (2) weeks. (7-1-99)T

02. Application. Until the facility applies for a special rate, patients with such needs will be included in the computation of the facility's rates following the principles described in Section 56-102, Idaho Code. (7-1-99)T

03. Approval. Approved special rates will become effective on the date the application is received, but no earlier than the first day of the month in which the application for a special rate was received. (7-1-99)T

04. Reporting. Costs equivalent to payments at the special rate will be removed from the cost components subject to limits, and will be reported separately. (7-1-99)T

05. Limitation. The reimbursement rate paid will not exceed the provider's charges to other patients for similar services. (7-1-99)T

311. PHASE-IN PROVISIONS.
The rates established pursuant to these rules shall be phased in over a three-year period as follows: (7-1-99)T

01. July 1, 1999 Through June 30, 2000. During this period, providers will continue to be reimbursed under the previous retrospective system; however, the Department will also issue by January 1, 2000 "shadow rates" which will inform facilities what their rate would be under the provisions of these rules. (7-1-99)T

02. July 1, 2000 Through December 31, 2000. Rates calculated under the provisions of these rules will be compared to the rates that were available to the same facility as of June 30, 1999. Facilities which would experience decreases in their rate of one dollar ($1) or less per resident day will receive the rate established under the provisions of these rules with no phase-in. Facilities which would experience decreases in their rate of greater than one dollar ($1) per resident day will have the decrease in their rate limited to the greater of one dollar ($1) per resident day or twenty-five percent (25%) of the decrease. Facilities which would experience increases in their reimbursement rate will receive the increased rate. (7-1-99)T

03. January 1, 2001, Through June 30, 2001. Rates calculated under the provisions of these rules will be compared to the rates that were available to the same facility as of June 30, 1999. Facilities which would experience decreases in their rate of two dollars ($2) or less per resident day will receive the rate established under the provisions of these rules with no phase-in. Facilities which would experience decreases in their rate of greater than two dollars ($2) per resident day will have the decrease in their rate limited to the greater of two dollars ($2) per

resident day or fifty percent (50%) of the decrease. Facilities which would experience increases in their reimbursement rate will receive the increased rate. (7-1-99)T

04. July 1, 2001. Beginning with July 1, 2001, the rates established under the provisions of these rules will be fully implemented with no phase-in. (7-1-99)T

312. OVERSIGHT COMMITTEE.
The Director will appoint an oversight committee to monitor implementation of the Prospective Payment System (PPS) for nursing facility reimbursement that takes effect July 1, 1999. The committee will be made up of at least one (1) member representing each of the following organizations: the Department, the state association(s) representing free standing skilled care facilities, and the state association(s) representing hospital-based skilled care facilities. The committee will continue to meet periodically subsequent to the implementation of the PPS. After three (3) years of implementation, the committee will examine the inflation factors used to inflate costs forward for rate setting (DRI + one percent (+1%), the inflation factors used in limiting the growth in the cost component limitations (DRI + two percent (+2%), and the level of the minimum cost component limitations (not lower than limits established July 1, 1999). (7-1-99)T

313. DISPUTES.

01. Administrative Review Requirement. If any facility wishes to contest the way in which a rule or contract provision relating to the prospective, cost-related reimbursement system was applied to such facility by the Director, it shall first pursue the administrative review process set forth in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 03, Section 300, et seq., and Section 301, "Rules Governing Contested Cases and Declaratory Rulings". (12-31-91)

02. Legal Challenge. The administrative review process need not be exhausted if a facility wishes to challenge the legal validity of a statute, rule, or contract provision. (12-31-91)

314. DENIAL, SUSPENSION, REVOCATION OF LICENSE OR PROVISIONAL LICENSE -- PENALTY.
The Director is authorized to deny, suspend, or revoke a license or provisional license or, in lieu thereof or in addition thereto, assess monetary penalties of a civil nature not to exceed one thousand dollars ($1000) per violation in any case in which it finds that the facility, or any partner, officer, director, owner of five percent (5%) or more of the assets of the facility, or managing employee: (12-31-91)

01. Failed Or Refused To Comply. Failed or refused to comply with the requirements of Sections 56-101 through 56-135, Idaho Code, or the rules established hereunder; or (1-1-82)

02. False Statements. Has knowingly or with reason to know made a false statement of a material fact in any record required by this chapter; or (1-1-82)

03. Refused To Allow Representative. Refused to allow representatives or agents of the Director to inspect all books, records, and files required to be maintained by the provisions of this chapter or to inspect any portion of the facility's premises; or (1-1-82)

04. Wilfully Prevented, Interfered With, Or Attempted To Impede Work. Wilfully prevented, interfered with, or attempted to impede in any way the work of any duly authorized representative of the Director and the lawful enforcement of any provision of this chapter; or (1-1-82)

05. Preservation Of Evidence. Wilfully prevented or interfered with any representative of the Director in the preservation of evidence of any violation of any of the provisions of this chapter. (12-31-91)

315. -- 349. (RESERVED).

350. AUDITS.
The objectives of an audit are: (1-16-80)

01. Accuracy Of Recording. To determine whether the transactions recorded in the books of record are substantially accurate and reliable as a basis for determining reasonable costs. (1-16-80)

02. Reliability Of Internal Control. To determine that the facilities internal control is sufficiently reliable to disclose the results to the provider's operations. (1-16-80)

03. Economy And Efficiency. To determine if Title XIX recipients have received the required care on a basis of economy and efficiency. (1-16-80)

04. Application Of GAAP. To determine if GAAP is applied on a consistent basis in conformance with applicable federal and state regulations. (1-16-80)

05. Patient Trust Fund Evaluation. To evaluate the provider's policy and practice regarding his fiduciary responsibilities for patients, funds and property. (1-16-80)

06. Enhancing Financial Practices. To provide findings and recommendations aimed at better financial practices to allow the most economical delivery of patient care. (1-16-80)

07. Compliance. To provide recommendations which will enable the provider to conform more closely with state and federal regulations in the delivery of health care to program recipients. (1-16-80)

08. Final Settlement. To effect final settlement when required by Sections 250 through 350 of this rule. (7-1-99)T

351. PRINCIPLE.
All financial reports will be subject to audit in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16.03.12, "Rules Governing Audits of Providers". (4-28-89)

352. APPLICATION.

01. Annual Audits. Normally, all annual statements will be audited within the following year. (1-16-80)

02. Limited Scope Audit. Other statements and some annual audit recommendations may be subject to limited scope audits to evaluate provider compliance. (1-16-80)

03. Additional Audits. In addition, audits may be required where: (1-16-80)

a. A significant change of ownership occurs. (1-16-80)

b. A change of management occurs. (1-16-80)

c. An overpayment of twenty-five percent (25%) or more has resulted for a completed cost period. (1-16-80)

04. Audit Appointment. Annual field audits will be by appointment. Auditors will identify themselves with a letter of authorization or Departmental I.D. cards. (1-16-80)

353. STANDARDS AND REQUIREMENTS.

01. Review Of New Provider Fiscal Records. Before any program payments can be made to a prospective provider the intermediary will review the provider's accounting system and its capability of generating accurate statistical cost data. Where the provider's record keeping capability does not meet program requirements the intermediary will offer limited consultative services or suggest revisions of the provider's system to enable the provider to comply with program requirements. (1-16-80)

02. Requirements. Section 2404.3 of the August, 1973 revision of the Providers Reimbursement

Manual (PRM) states: "Examination of Pertinent Data and Information -- Providers asking to participate as well as those currently participating must permit the intermediary to examine such records and documents as are deemed necessary." (7-1-99)T

03. Examination Of Records. Examination of records and documents may include, but not be limited to: (1-16-80)

a. Corporate charters or other documents of ownership including those of a parent or related companies. (1-16-80)

b. Minutes and memos of the governing body including committees and its agents. (1-16-80)

c. All contracts. (1-16-80)

d. Tax returns and records, including workpapers and other supporting documentation. (1-16-80)

e. All insurance contracts and policies including riders and attachments. (1-16-80)

f. Leases. (1-16-80)

g. Fixed asset records (see audit section - Capitalization of Assets). (1-16-80)

h. Schedules of patient charges. (1-16-80)

i. Notes, bonds and other evidences of liability. (1-16-80)

j. Capital expenditure records. (1-16-80)

k. Bank statements, cancelled checks, deposit slips and bank reconciliations. (1-16-80)

l. Evidence of litigations the facility and its owners are involved in. (1-16-80)

m. Documents of ownership including attachments which describe the property. (1-16-80)

n. All invoices, statements and claims. (1-16-80)

o. "Providers Accounting Firm. Where a provider engages an accounting firm to maintain its fiscal records, the financial audit workpapers prepared by the accounting firm are considered to be the property of the provider and must be made available to the intermediary upon request." (PRM, paragraph 2404.4(Q) of the Providers Reimbursement Manual) (7-1-99)T

p. Ledgers, journals, all working papers, subsidiary ledgers, records and documents relating to financial operation. (1-16-80)

q. All patient records, including trust funds and property. (1-16-80)

r. Time studies and other cost determining information. (1-16-80)

s. All other sources of information needed to form an audit opinion. (1-16-80)

04. Adequate Documentation. (1-16-80)

a. Adequacy of Cost Information. Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost, capable of being audited (PRM, Section 2304). (7-1-99)T

b. Expenses. Adequate documentation would normally include: an invoice, or a statement with invoices attached which support the statement. All invoices should meet the following standards: (1-16-80)

i. Date of service or sale; (1-16-80)

ii. Terms and discounts; (1-16-80)

iii. Quantity; (1-16-80)

iv. Price; (1-16-80)

v. Vendor name and address; (1-16-80)

vi. Delivery address if applicable; (1-16-80)

vii. Contract or agreement references; and (1-16-80)

viii. Description, including quantity, sizes, specifications brand name, services performed, etc.; (1-16-80)

c. Capitalization of Assets. Major movable equipment shall be capitalized. Minor movable equipment shall not be capitalized. The cost of fixed assets and major movable equipment must be capitalized and depreciated over the estimated useful life of the asset (PRM, Section 108.1). This rule shall apply except as to the provisions of Section 106 of PRM for small tools, etc. (7-1-99)T

i. Completed depreciation records must meet the following criteria for each asset: (1-16-80)

(1) Description of the asset including serial number, make, model, accessories, and location. (1-16-80)

(2) Cost basis should be supported by invoices for purchase, installation, etc. (1-16-80)

(3) Estimated useful life. (1-16-80)

(4) Depreciation method such as straight line, double declining balance, etc. (1-16-80)

(5) Salvage value. (1-16-80)

(6) Method of recording depreciation on a basis consistent with accounting policies. (1-16-80)

(7) Report additional information, such as additional first year depreciation, even though it isn't an allowable expense. (1-16-80)

(8) Reported depreciation expense for the year and accumulated depreciation shall tie to the asset ledger. (1-16-80)

ii. Depreciation Methods and Lives. (12-31-91)

(1) Methods. Straight line depreciation is always acceptable. Methods of accelerated depreciation are acceptable only upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. (4-28-89)

(2) Depreciable Lives. The life of any asset may not be shorter than the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, 1993 revised edition Guidelines Lives, which is hereby incorporated by reference into these rules. Deviation from these guidelines will be allowable only upon authorization from the Department. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. (7-1-99)T

iii. Lease Purchase Agreements. Lease purchase agreements may generally be recognized by the following characteristics: (1-16-80)

(1) Lessee assumes normal costs of ownership, such as taxes, maintenance, etc.; (4-28-89)

(2) Intent to create security interest; (1-16-80)

(3) Lessee may acquire title through exercise of purchase option which requires little or no additional payment or, such additional payments are substantially less than the fair market value at date of purchase; (1-16-80)

(4) Noncancellable or cancellable only upon occurrence of a remote contingency; and (1-16-80)

(5) Initial loan term is significantly less than the useful life and lessee has option to renew at a rental price substantially less than fair rental value. (1-16-80)

iv. Assets acquired under such agreements will be viewed as contractual purchases and treated accordingly. Normal costs of ownership such as depreciation, taxes and maintenance will be allowable as determined in this chapter. Rental or lease payments will not be reimbursable. (12-31-91)

d. Personnel. Complete personnel records normally contain the following: (1-16-80)

i. Application for employment. (1-16-80)

ii W-4 Form. (1-16-80)

iii. Authorization for other deductions such as insurance, credit union, etc. (1-16-80)

iv. Routine evaluations. (1-16-80)

v. Pay raise authorization. (1-16-80)

vi. Statement of understanding of policies, procedures, etc. (1-16-80)

vii. Fidelity bond application (where applicable). (1-16-80)

05. Internal Control. (1-16-80)

a. A system of internal control is intended to provide a method of handling all routine and nonroutine tasks for the purpose of: (1-16-80)

i. Safeguarding assets and resources against waste, fraud, and inefficiency. (1-16-80)

ii. Promoting accuracy and reliability in financial records. (1-16-80)

iii. Encouraging and measuring compliance with company policy and legal requirements. (1-16-80)

iv. Determining the degree of efficiency related to various aspects of operations. (1-16-80)

b. An adequate system of internal control over cash disbursements would normally include: (1-16-80)

i. Payment on invoices only, or statements supported by invoices. (1-16-80)

ii. Authorization for purchase such as a purchase order. (1-16-80)

iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. (1-16-80)

iv. Verification of freight charges, discounts, credit memos, allowances, and returns. (1-16-80)

v. Check of invoice accuracy. (1-16-80)

vi. Approval policy for invoices. (1-16-80)

vii. Method of invoice cancellation to prevent duplicating payment. (1-16-80)

viii. Adequate separation of duties between ordering, recording, and paying. (1-16-80)

ix. System separation of duties between ordering, recording, and paying. (1-16-80)

x. Signature policy. (1-16-80)

xi. Prenumbered checks. (1-16-80)

xii. Statement of policy regarding cash or check expenditures. (1-16-80)

xiii. Adequate internal control over the recording of transactions in the books of record. (1-16-80)

xiv. An imprest system for petty cash. (1-16-80)

06. Accounting Practices. Sound accounting practices normally include the following: (1-16-80)

a. Written statement of accounting policies and procedures, including policies of capitalization, depreciation and expenditure classification criteria. (1-16-80)

b. Chart of accounts. (1-16-80)

c. A budget or operating plan. (1-16-80)

354. PATIENT FUNDS.
The safekeeping of patient funds, under the program, is the responsibility of the provider. Accordingly, the administration of these funds requires scrupulous care in recording all transactions for the patient. (1-16-80)

01. Use. Generally, funds are provided for personal needs of the patient to be used at the patient's discretion. The provider agrees to manage these funds and render an accounting but may not use them in any way. (1-16-80)

02. Provider Liability. The provider is subject to legal and financial liabilities for committing any of the following acts. This is only a partial listing of the acts contrary to federal regulations: (1-16-80)

a. Management fees may not be charged for managing patient trust funds. These charges constitute double payment as management is normally performed by an employee of the provider and their salary is included in reasonable cost reimbursement. (1-16-80)

b. Nothing is to be deducted from these funds, unless such deductions are authorized by the patient or his agent in writing. (9-1-85)

c. Interest accruing to patient funds on deposit is the property of the patients and is part of the personal funds of each patient. The interest from these funds is not available to the provider for any use, including patient benefits. (1-16-80)

03. Fund Management. Proper management of such funds would include the following as minimum: (1-16-80)

a. Savings accounts, maintained separately from facility funds. (1-16-80)

b. An accurate system of supporting receipts and disbursements to patients. (1-16-80)

c. Written authorization for all deductions. (1-16-80)

d. Signature verification. (1-16-80)

e. Deposit of all receipts of the same day as received. (1-16-80)

f. Minimal funds kept in the facility. (1-16-80)

g. As a minimum these funds must be kept locked at all times. (1-16-80)

h. Statement of policy regarding patient's funds and property. (1-16-80)

i. Periodic review of these policies with employees at training sessions and with all new employees upon employment. (1-16-80)

j. System of periodic review and correction of policies and financial records of patient property and funds. (1-16-80)

355. DRUGS.
The rules governing payment for prescription drugs to outpatients are contained in Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, Sections 126 through Subsection 090.01, "Rules Governing Medical Assistance". (12-31-91)

01. Nonlegend Drugs. (7-1-93)

a. For providers which have no pharmacy on the premises, reimbursement will be available for nonlegend drugs subject to a test of reasonableness related to the market place and must not exceed the pharmacist's charges to private pay patients. This means that charges to the patient may not exceed the billing to the provider including, but not limited to, adjustments by discounts or terms. (9-1-85)

b. For providers who have a pharmacy on the premises, reimbursement will be available for nonlegend drugs at cost plus a dispensing fee established by the Division of Medicaid. (7-1-99)T

02. Record-Keeping Requirements. According to requirements in the Providers Reimbursement Manual PRM, Section 2104, the provider, as part of its financial record keeping responsibility under the program, must have on supplier invoices all needed cost verification information including name brand, quantity, form and strength of the drugs supplied and the provider's actual cost. In the absence of such information and in accordance with Section 1815 of the Social Security Act and Section 405.453 of the regulations, the Department must deny charges for unlabeled drugs because of inadequate records. Any cost reductions received on drug purchases including, but not limited to, discounts (cash, trade, purchase and quantity), or rebates, must also be clearly reflected on the individual invoices or related documentation. (7-1-99)T

356. ACCOUNTING TREATMENT.
Generally accepted accounting principles, concepts, and definitions shall be used except as otherwise specified. Where alternative treatments are available under GAAP, the acceptable treatment will be that one which most clearly attains program objectives. (1-16-80)

01. Final Payment. A final settlement will be made based on the reasonable cost of services as determined by audit, limited in accordance with other sections of this chapter. In addition, an efficiency incentive will be allowed to low cost providers in accordance with the provisions of Section 255. (12-31-91)

02. Overpayments. As a matter of policy, recovery of overpayments will be attempted as quickly as possible consistent with the financial integrity of the provider. (1-16-80)

03. Other Actions. Generally overpayment shall result in two (2) circumstances: (1-16-80)

a. If the cost report is not filed the sum of the following shall be due: (1-16-80)

i. All payments included in the period covered by the missing report(s). (1-16-80)

ii. All subsequent payments. (1-16-80)

b. Excessive reimbursement or noncovered services may precipitate immediate audit and settlement for the period(s) in question. Where such a determination is made, it may be necessary that the interim reimbursement rate (IRR) will be reduced. This reduction shall be designated to effect at least one of the following: (1-16-80)

i. Discontinuance of overpayments (on an interim basis). (1-16-80)

ii. Recovery of overpayments. (1-16-80)

357. -- 399. (RESERVED).

400. PROVIDER RIGHTS AND OBLIGATIONS.

01. Provider Rights. (7-1-93)

a. Appeal Procedure. Provisions for appealing interim rates, program determinations, or final audit reports are contained in Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, Sections 330, et seq., and Section 301, "Rules Governing Contested Cases and Declaratory Rulings". (12-31-91)

b. Clarification. Providers shall have the right to receive information, clarification, etc., about policies, recommendations or criteria set forth in the Title XIX guidelines. (1-16-80)

c. Clarification. Providers or their agents may write, call or appear in person to receive clarification regarding any policy, procedure or requirement of the program. (1-16-80)

i. Telephone calls are acceptable for the conveyance of general information but present confidentiality and other problems. Therefore, their use is limited. (1-16-80)

ii. Written requests are preferred for special requests or clarification. In some cases written requests may be required. (1-16-80)

iii. Personal inquiries are always welcome. An atmosphere of cooperation between providers and the Department is encourages. Such a relationship facilitates the type of information exchange and responsibility that the Department has assumed as intermediary in the program. In order to reasonably ensure the availability of staff for appointments, it would be well to confirm an appointment prior to arrival. (1-16-80)

d. Consultant Services. All providers may use the Department as a consultant to the extent that such activities relate to patient care. (1-16-80)

e. Withdrawal. All providers have the right to withdraw from program participation as specified in the state of Idaho, Title XIX Medicaid Provider Agreement. (1-16-80)

02. Provider Obligations. Providers and their agents shall be obligated to operate in a manner consistent with overall economy and efficiency. (1-16-80)

a. Provider Agreement Provisions. Providers may not enter into any agreement or transaction which violates their provider agreement or position of trust regarding program beneficiaries. (1-16-80)

b. Notification. All providers will be required to notify the intermediary of significant changes in ownership, management, policies, or procedures. This shall also apply to any entity related to the provider. (1-16-80)

c. Providing Information. Providers shall be obligated to provide all requested information, documents, etc., to Departmental auditors. Failure to comply may result in disallowances. (1-16-80)

d. Changes in Fiscal Years. Providers are required to report a change in fiscal year. (1-16-80)

e. Reporting. Providers are required to notify the Department when there is a change in interim rates, entry into or withdrawal from the Title XVIII Medicare Program. (1-16-80)

401. (RESERVED).

402. IDAHO OWNER-ADMINISTRATIVE COMPENSATION.
Allowable compensation to owners and persons related to owners who provide any administrative services shall be limited based on the schedule in this Section. (7-1-97)

01. Allowable Owner Administrative Compensation. The following schedule shall be used in determining the maximum amount of owner administrative compensation allowable for the calendar year ending December 31, 1996.

Licensed Bed Range	Upper limit
51 - 100	67,300
101 - 150	74,025
151 - 250	100,525
251 - up	144,300

(7-1-97)

02. The Administrative Compensation Schedule. The administrative compensation schedule in this Section shall be adjusted annually based upon the change in average hourly earnings in nursing and personal care facilities as published by Data Resources Incorporated, its successor organization or, if unavailable, another nationally recognized forecasting firm. (7-1-97)

03. The Maximum Allowable Compensation. The maximum allowable compensation for an owner providing administrative services is determined from the schedule in Subsection 402.01. Allowable compensation will be determined as follows: (7-1-97)

a. In determining the number of beds applicable on the schedule, all licensed beds for which the individual provides administrative services shall be counted, regardless of whether they are in the same facility. (7-1-97)

b. For an owner providing services to more than fifty (50) beds, the amounts shown on the schedule for the applicable number of beds will determine the upper limit for allowable compensation. (7-1-97)

c. For owners providing services to less than fifty-one (51) beds, such services related to administrative duties will be reimbursed at the hourly rate allowable if the owner was providing services to fifty-one (51) beds. Additionally, services other than administrative services may be performed by the owner and shall be allowable at the reasonable market rate for such services. To be allowable, hours for each type of service shall be documented. In no event shall the total compensation for administrative and non-administrative duties paid to an owner or related party to an owner of a facility or facilities with fifty (50) licensed beds or less exceed the limit that would be applicable to an owner with the same number of points providing administrative services to facilities with fifty-one (51) beds as set forth in the schedule of Subsection 402.01 of these rules. (7-1-97)

04. Compensation For Persons Related To An Owner. Compensation for persons related to an owner

will be evaluated in the same manner as for an owner. (7-1-97)

05. When An Owner Provides Services To More Than One Provider. When an owner provides services to more than one (1) provider compensation will be distributed on the same basis as costs are allocated for non-owners. (7-1-97)

06. More Than One Owner Or Related Party May Receive Compensation For Hours Actually Worked. Services must be actually performed, documented and necessary. Total compensation must be reasonable, and not greater than the amount for which the same services could be obtained on the open market. The standard by which full time compensation is measured shall be two thousand eighty (2,080) hours. Compensation of an owner or a party related to an owner is subject to other provisions of this chapter, and shall not exceed the compensation determined from the Administrative Compensation Schedule, and, on an hourly basis, shall not exceed the compensation determined in the Administrative Compensation Schedule divided by two thousand eighty (2,080). (7-1-97)

403. -- 404. (RESERVED).

405. ANCILLIARY AND ROUTINE NURSING SUPPLIES.

01. Ancillary Supplies.

Ancillary Supplies
Artificial Limbs
Canes
Laboratory Tests
Legend Drugs and Insulin paid to facilities on a patient and prescription specific basis
Radiology
X-ray

(7-1-93)

02. Routine Supplies.

Routine Supplies
A & D Ointment
ABD Pad
Ace Bandages
Acquamatic K Pads
Air Mattress
Alcohol Applicators
Arm Slings
Asepto Syringes
Autoclave Sheets

Routine Supplies
Baby Powder
Band Aid Spots
Band Aids
Bandages/Elastic
Bandages/Sterile
Basins
Bed Frame Equipment
Bed Pans
Bedside Tissues
Benzoin Aerosol
Bibs
Bottles/Specimen
Braces
Butterfly Closures
Cannula/Nasal
Catheter Clamp
Catheter Plug
Catheter Tray
Catheters, any size
Catheters/Irrigation
Clinitest
Clysis Set
Coloplast
Cotton Balls
Crutches
Decubitus Ulcer Pads
Defecation Pads
Denture Cup
Deodorant
Dermassage
Disposable Leg Bag
Disposable Underpads

Routine Supplies
Donut Pad
Douche Bags
Drainage Bags
Drainage Sets
Drainage Tubing
Dressing/Sterile
Dressing Tray
Drugs Nonlegend
Enema Cans/Disposable
Enema/Fleets
Enema/Fleets in Oil
Female Urinal
Finger Cots
Flex Straws
Flotation Mattress
Foot Cradle
Gastric Feeding Tube
Gloves/Nonsterile
Gloves/Sterile
Gowns
Hand Feeding
Harris Flush Tube
Heat Cradle
Heating Pad
Heel Protectors
Hexol
Hot Pack Machine
Ice Bag
Identification Bands

Routine Supplies
Incontinency Care
Invalid Ring
IPPB Machine
Irrigation Bulb
Irrigation Set
Irrigation Solution
Irrigation Tray
IV Set
Jelly/Lubricating
Killet Ampules
Kleenex
Kling bandages/Sterile
KY Jelly
Levine Tube
Linen
Lotion
Maalox
Male Urinal
Massages
Medical Social Services
Medicine Cups
Medicine Dropper
Merthiolate Spray
Milk of Magnesia
Mineral Oil
Mouthwashes
Nasal Cannula
Nasal Catheter
Nasal Gastric Tube

Routine Supplies
Nasal Tube
Needles
Nonallergic Tape (paper tape)
Nursing Services
Occupational Therapy
Ointment/Skin Nonprescription
Overhead Trapese
Oxygen
Oxygen Equipment-IPPB
Oxygen Mask/Disposable
Oxygen/Nondisposable
Peroxide
Personal Laundry (except for dry cleaning and special laundry)
Pitcher
Physical Therapy*
Plastic Bib
Pumps*
Rectal Tube
Restraints
Room and Board
Sand Bags
Scalpel
Sheep Skin
Special Diets
Specimen Cup
Speech Therapy
Sponges/Sterile
Sterile Pads
Stomach Tube
Suction Machines

Routine Supplies
Suppositories
Surgical Dressings
Surgical Pads
Surgical Tape/Nonallergic
Suture Set Suture Tray
Swabs/Lemon & Glycerin
Tape (Lab-Testing)
Tape/Autoclave
Testing Sets/Refills
Thermometers
Tincture of Benzoin
Tongue Blades
Tracheostomy Sponges
Tray Service
Tubing/IV
Tubing/Blood
Tubing/Drainage
Urinals
Urinary Drainage Tube Underpads (if more than occasional use)
Urological Solutions
Vaseline
Walkers
Water Pitchers
Wheel Chairs
Water for Injection

*Subject to Department policy

(1-1-82)

406. (RESERVED).

407. COSTS FOR THE COMPLETION OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS (NATCEPs) IN NURSING FACILITIES (NFs) EXCLUDING ICF/MR FACILITIES AND FOR COMPLYING WITH CERTAIN OTHER REQUIREMENTS.
Provisions of federal law require the state to give special treatment to costs related to the completion of training and competency evaluation of nurse aides and to increase rates related to other new requirements. Treatment will be as follows: (9-28-90)

01. Cost Reimbursement. Effective for cost reports filed and for payments made after April 1, 1990, such NATCEP costs shall be outside the content of nursing facility care and shall be reimbursed separately as an ancillary cost. (9-28-90)

02. Costs Subject To Audit. Such NATCEP costs shall remain subject to audit, shall be reported separate from other costs, shall be reported by all NFs including those which are hospital based and will not be included in the percentile cap. (9-28-90)

03. Payment Adjustments. Beginning April 1, 1990, interim NF payments will be adjusted to exclude NATCEP costs from the content of NF care, separate payments covering such costs will be made, and payment rates will be revised to cover certain other costs. (9-28-90)

a. NATCEP's costs are not part of the content of nursing home care, are to be reported separately on cost reports by all NF's and are reimbursed separate from NF interim rates. Such costs incurred from July 1, 1988 through September 30, 1990 will be reimbursed at one hundred percent (100%) of reasonable cost; NATCEP costs incurred thereafter will be separately reimbursed based on the Medicaid share of reasonable costs. (9-28-90)

b. Reimbursement for new costs, other than NATCEP related costs, which result from Public Law 100-203 (OBRA 1987) will be incorporated in interim NF payments effective October 1, 1990 for those providers who document such costs by October 1, 1990. Acceptable documentation will include estimated wages and benefits for new employees or net increases in scheduled working hours for specific current employees in order to comply with new requirements under OBRA 1987. The Department will provide forms for listing items related to the added costs including: (9-28-90)

i. New employees; (9-28-90)

ii. Related new responsibilities; (9-28-90)

iii. Products and services added; (9-28-90)

iv. Products and services no longer required; (9-28-90)

v. Added hours required; (9-28-90)

vi. Wage rates and other costs related to the net added products and services; and (9-28-90)

vii. The benefits rate for the facility. (9-28-90)

c. Interim rate increases will be based on total estimated added annual costs divided by the number of annual patient days used in determining the remainder of the interim rate. These rate increases are subject to reevaluation and revision based on actual costs. Interim payments are intended to approximate as closely as possible the final settlement amount. The final settlement for increases related to new costs resulting from OBRAs will be no more or less than audited actual cost. There will be no percentile cap or efficiency increment applied to these new costs. (9-28-90)

d. A rate change for new costs related to OBRA 1987 will not count toward the limit of two (2) adjustments per year as addressed in Subsection 303.03. (12-31-91)

408. QUALITY INCENTIVES.
Nursing facility providers that are recognized for providing high quality care, based on determinations by the agency

of the Department that inspects and certifies such facilities for participation in the Medicaid program, shall be eligible for incentive payments. The amount of such payments and the basis therefore will be determined by the Director and will be paid in addition to any other payments for which the facility is eligible under other provisions of this chapter, including provisions related to limitations related to customary charges. However, such payments will be subject to available State and federal funds and will be postponed or omitted in the event that such payments along with other payments made to Nursing Facilities under this chapter would, in aggregate, exceed the estimated payments that would be made utilizing Medicare principles of cost reimbursement. (7-1-97)

409. -- 448. (RESERVED).

449. MAXIMUM PAYMENT TO HOSPITALS.
Pursuant to the provisions of Title XIX of the Social Security Act, in reimbursing hospitals, the Department will pay in behalf of MA recipients the lesser of Customary Charges or the Reasonable Cost of inpatient services in accordance with the procedures detailed in Sections 450 through 499. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment which would be determined as a Reasonable Cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement. (7-1-97)

450. EXEMPTION OF NEW HOSPITALS.
A hospital that has operated as the type of facility for which it is certified (or the equivalent thereof) under present and previous ownership for less than three (3) full years will be paid in accordance with the Title XVIII principles of Reasonable Cost reimbursement, including those provisions applicable to new providers for the carryover and recovery of unreimbursed costs, pursuant to 42 CFR Section 411.28 and Sections 413.30(g) and (h). (7-1-97)

451. DEFINITIONS.
In determining hospital reimbursement on the basis either of Customary Charges or of the Reasonable Cost of services under Medicaid guidelines, whichever is less, the following will apply: (7-1-99)T

01. Allowable Costs. The Current Year's Title XIX apportionment of a hospital's Allowable Costs determined at final or interim settlement consist of those costs permitted by the principles of reimbursement contained in the Provider Reimbursement Manual (PRM) and do not include costs already having payment limited by Medicaid rate file or any other Medicaid charge limitation. (7-1-99)T

02. Apportioned Costs. Apportioned Costs consist of the share of a hospital's total Allowable Costs attributed to Medicaid program recipients and other patients so that the share borne by the program is based upon actual services received by program recipients, as set forth in the applicable Title XVIII principles of cost reimbursement as specified in the PRM and in compliance with Medicaid reimbursement rules. (7-1-99)T

03. Capital Costs. For the purposes of hospital reimbursement, Capital Costs are those allowable costs considered in the settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes. (7-1-99)T

04. 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. (7-1-97)

05. Charity Care. Charity Care is care provided to individuals who have no source of payment, third-party or personal resources. (7-1-97)

06. Children's Hospital. A Children's Hospital is a Medicare certified hospital as set forth in 42 CFR Section 412.23(d). (7-1-97)

07. 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. (7-1-97)

08. Current Year. Any hospital cost reporting period for which Reasonable Cost is being determined will be termed the Current Year. (7-1-97)

09. 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 one hundred percent (100%) 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 453.02. (7-1-97)

10. Disproportionate Share Hospital (DSH) Allotment Amount. The DSH Allotment Amount determined by Health Care Financing Administration which is eligible for federal matching funds in any federal fiscal period for disproportionate share payments. (7-1-97)

11. Disproportionate Share Hospital (DSH) Survey. The DSH Survey is an annual data request from the Department to the hospitals to obtain the information necessary to compute DSH pursuant to Subsection 454.01. (7-1-97)

12. Disproportionate Share Threshold. The Disproportionate Share Threshold shall be: (7-1-97)

a. The arithmetic mean plus one (1) standard deviation of the Medicaid Utilization Rates of all Idaho Hospitals; or (7-1-97)

b. A Low Income Revenue Rate exceeding twenty-five percent (25%). (7-1-97)

13. Excluded Units. Excluded Units are distinct units in hospitals which are certified by Medicare according to 42 CFR Sections 412.25, 412.27 and 412.29 for exclusion from the Medicare prospective payment system. (7-1-97)

14. Hospital Inflation Index. For purposes of determining the rate of increases of historical and forecasted Title XIX Inpatient Operating Cost Limits, and interim rates, the DRI, Data Resources Incorporated, Type Hospital Market Basket quarterly moving average, or its successor, is the Hospital Inflation Index. (7-1-97)

15. Low Income Revenue Rate. The Low Income Revenue Rate is the sum of the following fractions, expressed as a percentage, calculated as follows: (7-1-97)

a. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues and cash subsidies of the hospital for inpatient services in the same cost reporting period; plus (7-1-88)

b. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in the same cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts and reduction in charges given to Medicare, Medicaid, other third-party payors, or cash for patient services received directly from state and local governments county assistance programs. (7-1-97)

16. Medicaid Inpatient Day. For purposes of DSH payments, an inpatient day is defined as a Medicaid inpatient day in a hospital for which there is also no Medicare inpatient day counted. (7-1-97)

17. Medicaid Utilization Rate (MUR). The MUR for each hospital will be computed using the Department's record of paid inpatient days for the fiscal year divided by the total inpatient days for the same fiscal year as reported in the DSH Survey. In this paragraph, the term "inpatient days" includes Medicaid swing-bed days, administratively necessary days, newborn days, days in specialized wards, days provided at an inappropriate level of care, and Medicaid inpatient days from other states. In this paragraph, "Medicaid inpatient days" includes paid days not counted in prior DSH Threshold computations. (7-1-99)T

18. Obstetricians. For purposes of an adjustment for hospitals serving a disproportionate share of low income patients, and in the case of a hospital located in a rural area, as defined by the federal Executive Office of Management and Budget, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. (7-1-88)

19. On-Site. A service location over which the hospital exercises financial and administrative control. “Financial and administrative control” means a location whose relation to budgeting, cost reporting, staffing, policy-making, record keeping, business licensure, goodwill and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location shall be in close proximity to the hospital where it is based, and both facilities serve the same patient population (e.g. from the same area, or catchment, within Medicare’s defined Metropolitan Statistical Area (MSA) for urban hospitals or thirty-five (35) miles from a rural hospital). (7-1-99)T

20. Operating Costs. For the purposes of hospital reimbursement, Operating Costs are the allowable costs included in the cost centers established in the finalized Medicare Cost Report to accumulate costs applicable to providing routine and ancillary services to patients for the purposes of cost assignment and allocation in the step-down process. (7-1-97)

21. Other Allowable Costs. Other Allowable Costs are those Reasonable Costs recognized under the Medicaid Reasonable Cost principles for services not subject to Medicaid limitations of coverage or reimbursement limits. Costs which are not reimbursed as Operating Costs, but recognized by Medicare principles as Allowable Costs will be included in the total Reasonable Costs. Other Allowable Costs include, but are not necessarily limited to, physician's component which was combined-billed, Capital Costs, ambulance costs, excess costs, carry-forwards and medical education costs. (7-1-97)

22. Principal Year. The Principal Year is the period from which the Title XIX Inpatient Operating Cost Limit is derived. (7-1-97)

a. For services rendered from July 1, 1987 through July 5, 1995, the Principal Year shall be the provider's fiscal year ending in calendar year 1984 in which a finalized Medicare Cost Report or its equivalent is prepared for Title XIX cost settlement. (7-1-97)

b. For inpatient services rendered after July 5, 1995, through June 30, 1998, the Principal Year shall be the provider's fiscal year ending in calendar year 1992 in which a finalized Medicare Cost Report, or its equivalent, is prepared for Title XIX cost settlement. (7-1-97)

c. For inpatient services rendered after June 30, 1998, the Principal Year shall be the provider's fiscal year ending in calendar year 1995 in which a finalized Medicare Cost Report or its equivalent is prepared for Title XIX cost settlement. (7-1-97)

23. Public Hospital. For purposes of Subsection 453.02, a Public Hospital is a hospital operated by a federal, state, county, city, or other local government agency or instrumentality. (7-1-97)

24. Reasonable Costs. Except as otherwise provided in Section 453, Reasonable Costs include 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. (7-1-97)

25. Reimbursement Floor Percentage. The percentage of allowable Medicaid costs guaranteed to hospitals with more than forty (40) licensed and Medicare certified inpatient beds during the following state fiscal years is as follows: (7-1-97)

a. State Fiscal Year Ending June 30, 1996 - eighty percent (80%); (7-1-97)

b. State Fiscal Year Ending June 30, 1997 - eighty-one percent (81%); (7-1-97)

c. State Fiscal Year Ending June 30, 1998 - eighty-two percent (82%); (7-1-97)

d. State Fiscal Year Ending June 30, 1999 - eighty-three percent (83%); (7-1-97)

e. State Fiscal Year Ending June 30, 2000 - eighty-four percent (84%); (7-1-97)

f. State Fiscal Year Ending June 30, 2001 - eighty-five percent (85%). (7-1-97)

26. TEFRA. TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248. (7-1-97)

27. Uninsured Patient Costs. For the purposes of determining the 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. An inpatient with insurance but no covered benefit for the particular medically necessary service, procedure or treatment provided is an uninsured patient. (7-1-99)T

28. Upper Payment Limit. The Upper Payment Limit for hospital services shall be as defined in the Code of Federal Regulations. (7-1-97)

452. TITLE XIX INPATIENT OPERATING COST LIMITS.
In the determination of Reasonable Costs, a separate Title XIX cost limit for the services rendered under the approved state plan will be in effect during the Current Year. Payments will meet the costs of an economically and efficiently operated facility when the Title XIX cost limit, in effect during the same Current Year, is applied. (7-1-97)

01. Title XIX Cost Limits For Dates Of Service Prior To A Current Year. The reimbursable Reasonable Costs for services rendered prior to the beginning of the Principal Year, but included as prior period claims in a subsequent period's Cost Report, will be subject to the same operating cost limits as the claims under settlement. (7-1-97)

02. Application Of The Title Xix Cost Limit After Effective Date Of Rules. In the determination of a hospital's Reasonable Costs for inpatient services rendered after the effective date of a Principal Year, a Hospital Inflation Index, computed for each hospital's fiscal year end, will be applied to the Operating Costs, excluding Capital Costs and Other Allowable Costs as defined for the Principal Year and adjusted on a per diem basis for each subsequent year under the Hospital Inflation Index. (7-1-97)

a. Each inpatient routine service cost center, as reported in the finalized Principal Year end Medicare Cost Report, will be segregated in the Title XIX cost limit calculation and assigned a share of total Title XIX inpatient ancillary costs. The prorated ancillary costs shall be determined by the ratio of each Title XIX routine cost center's reported costs to total Title XIX inpatient routine service costs in the Principal Year. (7-1-97)

b. Each routine cost center's total Title XIX routine service costs plus the assigned share of Title XIX inpatient ancillary costs of the Principal Year will be divided by the related Title XIX patient days to identify the total costs per diem in the Principal Year. (7-1-97)

i. The related inpatient routine service cost center's per diem capital and graduate medical education costs plus the prorated share of inpatient ancillary capital costs will be subtracted from the per diem amount identified in Subsection 452.02.b. to identify each inpatient routine service cost center per diem cost limit in the Principal Year. (7-1-97)

ii. If a provider did not have any Title XIX inpatient utilization or render any Title XIX inpatient services in an individual inpatient routine service cost center in the fiscal year serving as the Principal Year, the Principal Year for only those routine cost centers without utilization in the provider's Principal Year will be appropriately calculated using the information available in the next subsequent year in which Title XIX utilization occurred. (7-1-97)

c. Each routine cost center's cost per diem for the Principal Year will be multiplied by the Hospital Inflation Index for each subsequent fiscal year. (7-1-97)

d. The sum of the per diem cost limits for the Title XIX inpatient routine service cost centers of a hospital during the Principal Year, as adjusted by the Hospital Inflation Index, will be the Title XIX cost limit for Operating Costs in the Current Year. (7-1-97)

i. At the date of final settlement, reimbursement of the Title XIX Current Year inpatient routine cost centers plus the assigned ancillary costs will be limited to the total per diem Operating Costs as adjusted for each subsequent fiscal year after the Principal Year through the Current Year by the Hospital Inflation Cost Index.(7-1-97)

ii. Providers will be notified of the estimated inflation index periodically or Hospital Inflation Index (HCFA Market Basket Index) prior to final settlement only upon written request. (7-1-97)

453. ADJUSTMENTS TO THE TITLE XIX COST LIMIT.
A hospital's request for review by the Bureau of Medicaid Policy and Reimbursement, or its successor, concerning an adjustment to or exemption from the cost limits imposed under the provisions set forth in Sections 450 through 499, shall be granted under the following circumstances (see also Section 500): (7-1-97)

01. Adjustments. Because of Extraordinary Circumstances. Where a provider's costs exceed the Title XIX limit due to extraordinary circumstances beyond the control of the provider, the provider can request an adjustment to the cost limit to the extent the provider proves such higher costs result from the extraordinary circumstances including, but not limited to, increased costs attributable to strikes, fires, earthquake, flood, or similar, unusual occurrences with substantial cost effects. (7-1-97)

02. Reimbursement To Public Hospitals. A Public Hospital that provides services free or at a nominal charge, which is less than, or equal to fifty percent (50%) of its total allowable costs, will be reimbursed at the same rate that would be used if the hospital's charges were equal to, or greater than, its costs. (7-1-97)

03. Adjustment To Cost Limits. A hospital shall be entitled to a reasonable increase in its Title XIX Cost limits if the hospital shows that its per diem costs of providing services have increased due to increases in case-mix, the adoption of new or changed services, the discontinuation of services or decrease in average length of stay for Medicaid inpatients since the Principal Year. Any hospital making such showing shall be entitled to an increase commensurate with the increase in per diem costs. (7-1-97)

a. The Title XIX operating cost limit may be adjusted by multiplying cost limit by the ratio of the Current Year's Case-Mix Index divided by the Principal Year's Case-Mix Index. (7-1-99)T

b. The contested case procedure set for forth in IDAPA 16.05.03.330.02, "Rules Governing Contested Case Proceedings and Declaratory Rulings," shall be available to larger hospitals seeking such adjustments to their Title XIX Cost Limits. (7-1-97)

04. Hospitals With Forty Or Fewer Licensed And Medicare Certified Beds. Hospitals with forty (40) or fewer licensed and Medicare certified beds, excluding nursery and neonatal intensive care bassinets, will be guaranteed one hundred percent (100%) of their allowable Medicaid Operating and Capital and medical education costs upon final settlement excluding DSH payments. (7-1-97)

05. Hospitals With More Than Forty Licensed And Medicare Certified Beds. Hospitals with more than forty (40) licensed and Medicare certified beds will be guaranteed at least eighty percent (80%) of their total allowable Medicaid Operating and Capital and medical education costs upon final settlement excluding DSH payments. (7-1-97)

a. With the exception of Subsection 453.05.b., at the time of final settlement, the allowable Medicaid costs related to each hospital's fiscal year end will be according to the Reimbursement Floor Percentage defined for each state fiscal year end. (7-1-97)

b. In the event that HCFA informs the Department that total hospital payments under the Inpatient Operating Cost Limits exceed the inpatient Upper Payment Limit, the Department may reduce the guaranteed percentage defined as the Reimbursement Floor Percentage to hospitals with more than forty (40) licensed and Medicare certified beds to the level of the previous year. (7-1-97)

06. Adjustment To The Proration Of Ancillary Costs In The Principal Year. Where the provider asserts that the proration of ancillary costs does not adequately reflect the total Title XIX cost per diem calculated for the inpatient routine service cost centers in the principal year, the provider may submit a detailed analysis of ancillary services provided to each Title XIX recipient for each type of patient day during each recipient's stay during the principal year. The provider will be granted this adjustment only once upon appeal for the first cost reporting year that the limits are in effect. (7-1-99)T

454. ADJUSTMENT FOR DISPROPORTIONATE SHARE HOSPITALS (DSH).
All hospitals serving a disproportionate share of low income patients must qualify either as a Mandatory DSH or as Deemed DSH to receive a DSH payment. (7-1-97)

01. DSH Survey Requirements. On or before January 31, of each calendar year, the Department will send each hospital a DSH Survey. Each hospital shall return the DSH Survey on or before May 31 of the same calendar year. A hospital shall not be entitled to a DSH payment if the hospital fails to return the DSH Survey by the May 31 deadline without good cause as determined by the Department. From the DSH Survey and Department data, payments distributing the state's annual DSH allotment amount will be made by September 30 of the same calendar year. (7-1-97)

02. Mandatory Eligibility. Mandatory Eligibility for DSH status shall be provided for hospitals which: (7-1-99)T

a. Meet or exceed the disproportionate share threshold as defined in Subsection 451.13. (7-1-97)

b. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services, and have provided such services to individuals entitled to such services under the Idaho Medical Assistance Program for the reporting period. (7-1-99)T

i. Subsection 454.02.b. does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or (7-1-97)

ii. Does not offer nonemergency inpatient obstetric services as of December 21, 1987. (7-1-88)

c. The MUR shall not be less than one percent (1%). (7-1-97)

d. If a hospital exceeds both disproportionate share thresholds, set forth in Subsection 451.13, and the criteria of Subsections 454.02.b. and 454.02.c. are met, the payment adjustment will be the greater of the amounts calculated using the methods identified in Subsections 454.02 f. through 454.02.j. (7-1-97)

e. In order to qualify for a DSH payment, a hospital located outside the state of Idaho shall: (7-1-97)

i. Qualify under the mandatory DSH requirements set forth in this Section; (7-1-97)

ii. Qualify for DSH payments from the state in which the hospital is located; and (7-1-97)

iii. Have fifty thousand dollars ($50,000) or more in covered charges for services provided to Idaho recipients during the year covered by the applicable DSH Survey. (7-1-99)T

f. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one (1) standard deviation and less than one and one-half (1 1/2) standard deviations above the mean of all Idaho hospitals shall receive a DSH payment equal to two percent (2%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-99)T

g. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one and one-half (1 1/2) standard deviations and less than two (2) standard deviations of the mean of all Idaho hospitals shall receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-99)T

h. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates exceeding two (2) standard deviations of the mean of all Idaho hospitals shall receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-99)T

i. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding twenty-five percent (25%) shall receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-99)T

j. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to, or exceeding, thirty percent (30%) shall receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-99)T

03. Out-Of-State Hospitals Eligible For Mandatory DSH Payments. Out-of-state hospitals eligible for Mandatory DSH payments will receive DSH payments equal to one half (1/2) of the percentages provided for Idaho hospitals in Subsections 454.02.d. through 454.02.j. (7-1-97)

04. Deemed Disproportionate Share Hospital (DSH). All hospitals in Idaho which have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days, and meet the requirements unrelated to patient day utilization specified in Subsection 454.02, will be designated a Deemed Disproportionate Share Hospital. Out of state hospitals will not be designated as Deemed DSH. The disproportionate share payment to a Deemed DSH hospital shall be the greater of: (7-1-97)

a. Five dollars ($5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or (7-1-99)T

b. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the DSH Allotment Amount, less the Mandatory DSH payment amount, divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals. (7-1-97)

05. Insufficient DSH Allotment Amounts. When the DSH Allotment Amount is insufficient to make the aggregate amount of DSH payments to each DSH hospital, payments to each hospital will be reduced by the percentage by which the DSH Allotment Amount was exceeded. (7-1-99)T

06. DSH Payments Will Not Exceed Costs. A DSH payment will not exceed the costs incurred during the year of furnishing services to individuals who are either eligible for medical assistance under the state plan or were uninsured for health care services provided during the year. (7-1-97)

a. Payments made to a hospital for services provided to indigent patients by a state or a unit of local government within a state shall not be considered a source of third party payment. (7-1-97)

b. Claims of uninsured costs which increase the maximum amount which a hospital may receive as a DSH payment must be documented. (7-1-99)T

07. DSH Will Be Calculated On An Annual Basis. A change in a provider's allowable costs as a result of a reopening or appeal will not result in the recomputation of the provider's annual DSH payment. (7-1-99)T

455. ORGAN TRANSPLANT AND PROCUREMENT REIMBURSEMENT.

Organ transplant and procurement services by facilities approved for kidneys, bone marrow, liver, or heart will be reimbursed the lesser of one hundred percent (100%) of Reasonable Costs under Medicare payment principles or Customary Charges. Follow up care provided to an organ transplant patient by a provider not approved for organ transplants will be reimbursed at the provider's normal reimbursement rates. Reimbursement to Independent Organ Procurement Agencies and Independent Histocompatibility Laboratories will not be covered. (7-1-97)

456. OUT-OF-STATE HOSPITALS.

01. Cost Settlements For Certain Out-Of-State Hospitals. Hospitals not located in the state of Idaho

will have a cost settlement computed with the state of Idaho if the following conditions are met: (10-1-91)

a. Total inpatient and outpatient covered charges are more than fifty thousand dollars ($50,000) in the fiscal year; or (7-1-97)

b. When less than fifty thousand dollars ($50,000) of covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department. (7-1-97)

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 and no greater than eighty percent (80%) of outpatient covered charges or, the Department's established fee schedule for certain outpatient services. These rates represent average inpatient and outpatient reimbursement rates paid to Idaho hospitals. (7-1-97)

457. OUTPATIENT HOSPITAL SERVICES.
Outpatient hospital services must be provided on-site. Covered outpatient services and items will be paid the lesser of Customary Charges or the Reasonable Cost of services. They will be paid in accordance with the Upper Payment Limit. (7-1-99)T

01. Hospital Outpatient Surgery. Those items furnished by a hospital to an outpatient in connection with Ambulatory Surgical Center must be surgical procedures covered by Idaho Medicaid. The aggregate amount of payments for related facility services, furnished in a hospital on an outpatient basis, is equal to the lesser of: (7-1-97)

a. The hospital's Reasonable Costs as reduced by federal mandates for certain Operating Costs, Capital Costs, Customary Charges; or (7-1-97)

b. The blended payment amount which is based on hospital specific cost and charge data and Medicaid rates paid to free-standing Ambulatory Surgical Centers (ASC). (7-1-97)

c. The blended rate for outpatient surgical procedures is equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the ASC amount. (7-1-97)

02. Hospital Outpatient Radiology Services. Radiology services include diagnostic and therapeutic radiology, CAT scan procedures, magnetic resonance imaging, ultrasound and other imaging services. The aggregate payment for hospital outpatient radiology services furnished will be equal to the lesser of: (7-1-97)

a. The hospital's Reasonable Costs; or (7-1-97)

b. The hospital's Customary Charges; or (7-1-97)

c. The blended payment amount for hospital outpatient radiology equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the Department's fee schedule amount. (7-1-97)

03. Reduction To Outpatient Hospital Costs. With the exception of Medicare designated sole community hospitals and rural primary care hospitals, all other hospital outpatient costs not paid according to the Department's established fee schedule, including the hospital specific component used in the blended rates, will be reduced by five and eight-tenths percent (5.8%) of Operating Costs and ten percent (10%) of each hospital's Capital Costs component. (7-1-97)

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 will be covered when admitted to a freestanding psychiatric hospital. (7-1-97)

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. (7-1-87)

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. (7-1-97)

461. AVAILABILITY OF RECORDS OF HOSPITAL PROVIDERS.
A participating hospital provider of services must make available to the Department in the state in which the facility is licensed, the provider's fiscal and other necessary records for the purpose of determining its ongoing record keeping capability and to ascertain information pertinent to the determination of the proper amount of program payments due the provider. (7-1-97)

462. INTERIM COST SETTLEMENTS.
The Department may initiate or a hospital may request an interim cost settlement based on the Medicare cost report as submitted to the Medicare Intermediary. (7-1-99)T

01. Cost Report Data. Interim settlement cost report data will be adjusted to reflect Medicaid payments and statistical summary reports sent to providers before the filing deadline. (7-1-97)

02. Hard Copy Of Cost Report. Hospitals which request to undergo interim cost settlement with Idaho Medicaid must submit a hard copy of the Medicare cost report to the Bureau of Medicaid Policy and Reimbursement, or its designee, upon filing with the Intermediary. (7-1-99)T

03. Limit Or Recovery Of Payment. The Department may limit a recovery or payment of an interim settlement amount up to twenty-five percent (25%) of the total settlement amount when the cost report information is in dispute. (7-1-99)T

463. NOTICE OF PROGRAM REIMBURSEMENT.
Following receipt of the finalized Medicare Cost Report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider which sets forth the amounts of underpayment or overpayment made to the provider. The notice of the results of the final retroactive adjustment shall be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Title XIX program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. Such action of recovery or suspension will continue even after a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments will be made to the settlement amount. (7-1-97)

01. Timing Of Notice. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the Cost Report from the Medicare Intermediary. (7-1-97)

02. Reopening Of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three (3) year period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the Cost Report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement. (7-1-97)

464. INTEREST CHARGES ON OVERPAYMENTS AND UNDERPAYMENTS TO HOSPITALS.
The Title XIX program will charge interest on overpayments, and pay interest on underpayments, to hospitals as follows: (7-1-87)

01. Interest After Sixty Days Of Notice. If full repayment from the indebted party is not received within sixty (60) days after the provider has received notice of program reimbursement, interest will accrue from the date of receipt of the notice of program reimbursement as defined in Section 460, and will be charged on the unpaid settlement balance for each thirty (30) day period that payment is delayed. Periods of less than thirty (30) days will be treated as a full thirty (30) day period, and the thirty (30) day interest charge will be applied to any unpaid balance. Each payment will be applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not an allowable interest expense. (7-1-97)

02. Waiver Of Interest Charges. When the Department determines an overpayment exists, it may waive interest charges if it determines that the administrative costs of collecting them exceed the charges. (7-1-87)

03. Rate Of Interest. The interest rate on overpayments and underpayments will be the statutory rate as set forth in Section 28-22-104(1), Idaho Code, compounded monthly. (7-1-87)

04. Retroactive Adjustment. The balance and interest shall be retroactively adjusted to equal the amounts that would have been due based on any changes which occur as a result of the final determination in the administrative appeal and judicial appeal process. Interest penalties shall only be applied to unpaid amounts and shall be subordinated to final interest determinations made in the judicial review process. (7-1-87)

465. RECOVERY METHODS.
Recovery shall be effected by one (1) of the following methods: (7-1-97)

01. Lump Sum Voluntary Repayment. Pursuant to the provider's receipt of the notice of program reimbursement, the provider refunds the entire overpayment to the Department. (7-1-87)

02. Periodic Voluntary Repayment. The provider shall request in writing that recovery of the overpayment be made over a period of twelve (12) months or less. The provider must adequately document the request by demonstrating that the financial integrity of the provider would be irreparably compromised if repayments occurred over a shorter period of time than requested. (7-1-87)

03. Department Initiated Recovery. The Department shall recover the entire unpaid balance of the overpayment of any settlement amount in which the provider does not respond to the notice of program reimbursement within thirty (30) days of receipt. (7-1-87)

04. Recovery From Medicare Payments. The Department may request that Medicare payments be withheld in accordance with 42 CFR, Section 405.375. (7-1-97)

466. NONAPPEALABLE ITEMS.
The formula for the determination of the Hospital Inflation Index, the principles of reimbursement which define allowable cost, non-Medicaid program issues, interim rates which are in compliance with state and federal rules, and the preliminary adjustments prior to final cost settlement determinations as supported by properly completed Cost Reports and audits must not be accepted as appealable items. (7-1-97)

467. INTERIM REIMBURSEMENT RATES.
The interim reimbursement rates are reasonable and adequate to meet the necessary costs which must be incurred by economically and efficiently operated providers which provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. (7-1-97)

01. Annual Adjustments. Interim rates will be adjusted at least annually based on the best information available to the Department. (7-1-87)

a. For hospitals with more than forty (40) beds, the interim rate will reflect the Title XIX Inpatient Operating Cost Limits used to set inpatient rates and the Reimbursement Floor Percentage. (7-1-97)

b. For hospitals with forty (40) or fewer beds, the interim rates will reflect one hundred percent (100%) of the Medicaid reasonable costs by determining the Medicaid cost-to-charge ratio from the most recent Medicare Cost Report submitted to the Department. (7-1-97)

02. Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (7-1-87)

03. Basis For Adjustments. The Department may make an adjustment based on the Medicare Cost Report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. (7-1-97)

04. Unadjusted Rate. The Title XIX interim reimbursement rate on file is synonymous with the term unadjusted rate used by other payors. (7-1-97)

468. HOSPITAL SWING-BED REIMBURSEMENT.
The Department will reimburse hospitals which meet the requirements found in IDAPA 16.03.09.161, "Rules Governing Medical Assistance". (7-1-97)

469. -- 499. (RESERVED).

500. DISPUTED PAYMENTS TO HOSPITALS.
If a hospital has a grievance or complaint or requests an exception to the requirements of IDAPA 16.05.03.101 and 330, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (7-1-97)

501. -- 699. (RESERVED).

700. REIMBURSEMENT OF FEDERALLY QUALIFIED HEALTH CENTERS.
Pursuant to the provisions of Section 6404 of the Omnibus Budget Reconciliation Act of 1989, and as provided in IDAPA 16.03.09.144, "Rules Governing Medical Assistance," services rendered by a federally qualified health center (FQHC) shall be covered effective retroactively to April 1, 1990. (7-1-97)

701. REIMBURSEMENT -- GENERAL.
The aggregate reimbursement for all covered services and supplies provided by an FQHC shall be equal to, no less than, and shall not exceed, one hundred percent (100%) of the reasonable costs related to patient care allowed under 42 CFR 413, and as appropriately clarified by the Secretary of Health and Human Services for Medicare principles of cost reimbursement. (7-1-99)

01. Screening Guidelines Of FQHC Staff Productivity. Payments for FQHC services will be subject to an evaluation of the reasonableness of the FQHC health care staff's productivity level, which will be determined by the following screening guidelines, not to exceed the maximum payment per encounter pursuant to Subsection 701.03. The allowable cost per encounter is calculated as the greater number of the actual total encounters, or the expected total encounters as defined in Subsections 701.01.a. through 701.01.c. below: (7-1-99)

a. A least four thousand two hundred (4,200) visits per year per full time equivalent physician employed by the FQHC; and (7-1-99)

b. At least two thousand one hundred (2,100) encounters per year per full time physician assistant or nurse practitioner employed by the FQHC; or (7-1-99)

c. If staffing levels consist of various combinations of physicians, nurse practitioners, physician assistants, a combined screening approach may be used. For example, if a FQHC has three (3) physicians and one (1) nurse practitioner, calculate the screening guidelines as follows: 3 x 4,200 = 12,600 plus 1 x 2,100 = 2,100 for a total of fourteen thousand seven hundred (14,700) visits. (7-1-99)

d. If the Medicare Intermediary waives or adjusts the total number of encounters determined under the

productivity guidelines for a specific fiscal period, the Department may also waive or adjust the productivity guidelines. (7-1-99)

e. A full time equivalent for purposes of this Section is two thousand eighty (2,080) hours per year, and/or forty (40) hours per week for fifty-two (52) weeks. (7-1-99)

02. Offset, Reclassified Or Excluded Costs. The costs of the specific following items and services are to be offset, reclassified, or excluded from Medicaid reasonable costs: (4-1-90)

a. Excessive and unreasonable costs which violate the prudent buyer concept are excluded from total costs; and (4-1-90)

b. Medicaid payments for presumptive eligibility screenings provided in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, Section 102, "Rules Governing Medical Assistance," shall be offset against the appropriate cost centers at cost settlement; and (12-31-91)

c. Special services related to pregnancy provided in Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, Section 101, "Rules Governing Medical Assistance",,with the exception of nutritional education and dietary monitoring and counseling as authorized in Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, Subsection 101.06, "Rules Governing Medical Assistance," will be included as encounters in cost report statistics and for cost settlement; (12-31-91)

i. Other ambulatory services not included in the definition of an encounter defined by Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, Subsection 144.02, "Rules Governing Medical Assistance," shall be reimbursed at one hundred percent (100%) of reasonable costs; (12-31-91)

ii. EPSDT screenings and the incidental services are a patient encounter. Services and items specifically not included in the Idaho Title XIX state plan but authorized as EPSDT services through Section 6403 of OBRA 1989 may be reimbursed on a fee for service basis or reported as other ambulatory services for cost settlement; (4-1-90)

iii. EPSDT services not outside the scope of Medicaid shall be reimbursed at one hundred percent (100%) of reasonable costs for MA recipients up to and including the month of their twenty first (21st) birthday. Limits upon the number or scope of services for EPSDT recipients are not waived for a FQHC provider. (4-1-90)

03. Maximum Payment Per Encounter. The cost per encounter will not exceed the Medicare payment level. The FQHC reimbursement methodology includes one (1) urban and one (1) rural payment limit that is determined annually for the Medicare program by the Health Care Financing Administration. (7-1-99)

702. REASONABLE COSTS OF FQHC SERVICES.

01. Off-Site Physician Services. Off-site physician services outside the scope of allowable services of an FQHC will be reimbursed according to the Department's established fee schedule for such services. (4-1-90)

02. Ambulatory Service Costs. Ambulatory services shall not be considered an encounter. The direct costs and related customary charges of each ambulatory service provided shall be accounted for in an independent cost center in the provider's financial records and the Medicaid cost report. (4-1-90)

03. Overhead Costs. Overhead costs shall be allocated to core services, each category of other ambulatory services and nonallowable services in proportion of the cost of each to total cost. (4-1-90)

04. Employee Salaries Or Wages. Payments under the National Health Services Corps reimbursement program for employee salaries or wages shall not be offset against allowable costs. (4-1-90)

05. Other Ambulatory Services. Other ambulatory services will be reimbursed no more than the lesser of allowable costs or the reasonable costs reimbursed by Medicare for the same services. (4-1-90)

703. COST REPORT FILING REQUIREMENTS.
Each FQHC provider shall submit the completed Medicaid cost report form containing such information and worksheets as the Department requires to determine Medicaid reasonable costs. The deadline will be the last day of the third month following the provider's fiscal period unless a delay is granted by the Department. (4-1-90)

01. Delay Of Deadline. A delay of thirty (30) days past the filing deadline may be granted by the Department if a written request for deferral of submittal is received prior to the filing deadline. The request must state specifically the reasons and/or extraordinary circumstances which have occurred to make timely submittal of the report impossible. (4-1-90)

02. Failure To File. If a provider fails to file a complete cost report by the first day of each calendar month subsequent to the deadline, the Department shall withhold interim payments until the provider complies. The Department shall send a notice of reduction in the encounter rate and withhold payments as follows: (4-1-90)

a. A ten percent (10%) reduction shall be effective the second Friday of the first calendar month after the provider's deadline; (4-1-90)

b. Continued failure to comply shall result in the complete suspension of payments on the second Friday of the second month following the deadline: (4-1-90)

c. Continued failure to comply by the last day of the third month following the deadline shall be a breach of the Medicaid provider agreement. The provider shall be ineligible for subsequent payments from this date; (4-1-90)

d. Upon submittal of acceptable and complete cost reporting forms, not withstanding Subsection 703.02.e., all withheld payments shall be restored to the provider without interest charges; (12-31-91)

e. Refusal or continued failure to comply within thirty (30) days of Medicaid suspension per Subsection 703.02.c., shall be grounds for retrospective recovery of all Medicaid payments for the fiscal period to be cost settled. The provider shall be terminated from the Medicaid program for at least six (6) months after payment recovery is complete. (12-31-91)

03. Audit Or Desk Review. If certain cost items are discovered during an audit or desk review which are not related to patient care, the Department staff shall make the necessary adjustments to correct the report and inform the provider of the changes made. (4-1-90)

a. If these same nonallowable costs appear on a subsequent cost report, the provider shall be notified why certain costs were disallowed and that inclusion of the same nonallowable costs in the next cost report could be treated as program abuse and referred to the appropriate agencies for consideration of criminal and/or civil prosecution, or other Departmental sanctions; (4-1-90)

b. There shall be no referral where the allowability of a cost report item has been disputed and the provider has clearly indicated on the subsequent report that the particular item is still in dispute and is being included in the cost report only to establish the basis for an appeal. (4-1-90)

04. Consolidated Cost Reports. Costs of individual provider sites may be determined through consolidated cost reports only if prior authorization by the Department is granted prior to the beginning of the respective fiscal year. (4-1-90)

a. Authorization for consolidated cost reports shall be given only when there is no significant difference between the types of services and the related customary charges or costs as provided to the general public or Medicaid population served by each site. (4-1-90)

704. ADEQUACY OF COST INFORMATION.
The FQHC must maintain records which identify the costs and charges of the covered services from the site where the service was provided and which at least account for the following: (4-1-90)

01. Physician Time Spent. The FQHC must identify the time which each physician spent in direct patient care and administrative activities. (4-1-90)

02. Reconcile Direct Costs. The FQHC must reconcile the direct costs and related customary charges of each service not incorporated into the encounter rate in each fiscal period's Medicaid cost report. (4-1-90)

03. Central Office Costs. Allowable central office or home office costs must be allocated to individual provider sites under a reasonable and consistent basis which reflects the number of encounters and the utilization costs of each category of ambulatory services at each site. The worksheets and method of location to each site must also be available upon the Department's request. (4-1-90)

705. INTERIM PAYMENT RATES.
The encounter rate for each FQHC site will be determined on the information which best estimates the reasonable costs of services for a fiscal period. Ambulatory services not included in the definition of an encounter will be reimbursed, subject to the restrictions on the number or type of services allowed to any recipient, as a Medical Assistance benefit during the interim before cost settlement according to fee schedules on file for the services provided. (4-1-90)

01. Interim Encounter Rates. Interim encounter rates should reflect the total estimated Medicaid costs of core services, plus or minus any difference between the Department's interim fee-for-service payments and the reasonable costs of other ambulatory services divided by the total number of anticipated Medicaid encounters. (4-1-90)

02. Rate Adjustments. Rate adjustments may be requested by the provider no more than twice in each provider's fiscal year. Rate adjustment requests must be specific as to the amount in question, and be accompanied by information which supports the provider's request which includes, but is not limited to, audited or interim financial statements, budget data, management information data, pro-forma cost reports, patient utilization data and costs of new services or equipment, or specific information the Department requests. (4-1-90)

706. COST SETTLEMENTS.
The Department shall issue interim and final cost settlements based on the Medicaid cost report issued by the Department. (6-1-99)T

01. Unaudited Cost Report. Within sixty (60) days of receipt of a FQHC provider's unaudited cost report, the Department shall review the cost report submitted, notwithstanding any appropriate adjustments the Department may make, in order to issue a tentative settlement to reimburse the FQHC for any underpayment or recover overpayment for the fiscal period to be settled. (6-1-99)T

02. Audited Cost Report. Within thirty (30) days after each provider's audited cost report is finalized by the Department's agent, the Department shall reimburse a FQHC for any underpayments or recover any overpayments made for the fiscal period represented in the audited report. (6-1-99)T

707. INTEREST CHARGES ON OVERPAYMENTS AND UNDERPAYMENTS FOR COST SETTLEMENTS.
The Department shall charge interest on overpayments and pay interest on underpayments to providers according to Section 461. (12-31-91)

708. AUDITS.
All financial reports are subject to audit by Departmental representatives per Sections 350 through 399. (12-31-91)

709. -- 995. (RESERVED).

996. ADMINISTRATIVE PROVISIONS.
Contested case appeals shall be governed by IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (7-1-97)

997. CONFIDENTIALITY OF RECORDS.
Information received by the Department in connection with Medicaid provider reimbursement is subject to the provisions of IDAPA 16.05.01, "Rules Governing Protection and Disclosure of Department Records". (7-1-97)

998. -- 999. (RESERVED).

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