Idaho Hospital Association

HOSPITALS 101

A guide to Idaho's Community Hospitals

2025 edition

Dear Idaho Legislators,

On behalf of Idaho's 51 hospitals and nearly 35,000 dedicated healthcare workers represented by the Idaho Hospital Association (IHA), we extend our heartfelt thanks for your service to the people of Idaho.

As members of a citizen Legislature, you face the challenging task of navigating a vast array of issues, particularly when considering the financial, legal, and policy implications of the hundreds of bills presented each year. We hope that you will view the IHA, along with this document, as a valuable resource to help guide your decision-making process.

The *Hospitals 101* guide was created to provide you with essential information to better understand the complexities of healthcare legislation and support you in addressing these critical issues with your constituents. This guide will help provide detailed background information on things like payment methodologies and serve as a quick reference to the many acronyms and processes that are an intrinsic part of healthcare.

As one of the fastest growing states in the country, the health of our economy and our citizens depends on a robust healthcare infrastructure that ensures access to high-quality care for all. We stand ready to serve as your partner and resource in this important work for all Idahoans.

Please don't hesitate to reach out with any questions or concerns. Best wishes for a productive and successful session!

Warm regards,

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Idaho Hospital Association

Idaho's Community Hospitals
SNAPSHOT

20,682
Births

610,368
Emergency Visits

149,379
Inpatient Admissions

5.8 mil
Outpatient Encounters

34,957
hospital employees

direct contribution to Idaho's GSP
$6.21 bil.

* Based on 2023 Data

*** most recent 10-yr data available**

24 / 7 / 365 --- that's how Idaho's emergency departments run. When your loved one is having chest pain or has been in an accident, healthcare workers are ready to answer the call. But the ED isn't always the best or least costly place for care. Idaho's hospitals have worked for years helping Idahoans get the right care at the right time in the right place. Preventive care, community outreach and education, and a commitment to primary care all help guide patients to get their care in the best setting. This means, while our population has skyrocketed, the number of ED visits has remained disproportionately low.

The Unique Role of Hospitals

Idaho's hospitals play a vital role in meeting the healthcare needs of their communities. They provide a wide range of acute care and diagnostic services, supporting public health needs, providing access to primary care, and offering countless other community services to promote the health and well-being of the community.

While some hospital services are also delivered by other healthcare providers, three things make the role of the hospital unique:

- **24/7 Access to Care**: Hospitals are committed to providing healthcare services, including specialized resources, 24/7, 365 days a year. Always there, ready to care is more than a tagline. It's what drives our healthcare workers to make sure our doors are open for everyone in times of need.
- **The Safety-Net Role**: Being ready to care for any patient who seeks emergency care, regardless of one's ability to pay, is a cornerstone practice at Idaho's acute care hospitals.
- **Disaster Readiness & Response**: Ensuring that staff and facilities are prepared to care for victims of large-scale accidents or attacks, natural disasters, and epidemics is built into Idaho's hospital operations.

These critical roles – collectively known as the "standby" role – while often taken for granted, represent an essential component of our nation's health and public safety infrastructure. The standby role of hospitals is not explicitly funded; instead, the funding is built into a hospital's overall cost structure. Hospital staff train and prepare for a variety of situations and work in partnership with state and local officials to be ready when critical events happen.

For many rural Idaho communities, local hospitals are vital to the support of emergency services, access to pharmacies, and are key in addressing mental health crises.

Idaho Hospital Association Members

IHA represents 51 hospitals throughout the state. A majority of our members, 39, are full-service, community hospitals that provide 24/7 care in their communities. In addition to the hospital, some of our members manage nursing homes, clinics, and rural health centers. IHA also represents five behavioral health, two long-term acute care, three rehabilitation, and one veterans hospital. Hospital designations include:

Critical Access Hospitals (CAH): This designation is given to certain rural hospitals by the federal government. Implemented in 1997, this designation is intended to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities. As of July 1, 2022, CAHs are reimbursed 99% of Medicare rates on allowable costs. Twenty-seven of Idaho's community hospitals have the CAH designation. The primary requirements to maintain CAH status are:

- providing 24/7 emergency care services;
- having 25 or fewer acute care inpatient beds;
- being located more than 35 miles from another hospital (exceptions may apply); and,
- maintaining an annual average length of stay of 96 hours or less for acute care patients.

Prospective Payment Systems (PPS): Another federal designation, PPS refers to the method of Medicare reimbursement where payments are made based on a predetermined, fixed amount for services. The payment amount for a particular service is derived based on classification systems; DRGs (diagnosis-related group) for inpatient care and APCs (ambulatory payment classifications) for outpatient care. Overall, reimbursements to PPS hospitals from Medicare do not cover the actual cost of providing the care. There are 13 full-service PPS hospitals in our membership and an additional 11 that are state, federal, mental health, rehabilitation, or long-term acute care.

Rural Emergency Hospital (REH): The REH designation was created by Congress in 2021 to help rural hospitals avoid closure and to improve access to healthcare in rural areas. REHs provide emergency services and certain outpatient services to patients who typically stay less than 24 hours. No Idaho hospitals have yet converted to this new designation, but there are Idaho communities that have difficulties sustaining their Critical Access Hospital that are actively evaluating this opportunity.

IHA Member Hospitals

Hospital Ownership

The following definitions provide clarification on the various types of hospitals that exist in Idaho. All Idaho hospitals are defined and licensed under sections 39-1301 through 39-1314 of Idaho Code.

Non-Profit or Not-for-Profit Hospitals

A not-for-profit hospital is an organization that can demonstrate that no part of its net earnings is given to a shareholder or individual. The term non-profit does not mean that the hospital does not make a margin. Instead, "profits" of the hospital are returned to the control of the hospital for operations rather than to shareholders. A not-for-profit hospital is exempt from most federal and state taxes due to its charitable status, but is not exempt from employment taxes (e.g., Social Security and Medicare taxes). Hospital-owned properties may or may not be exempt from local property tax based on how the property is being used. Idaho has 22 not-for-profit hospitals.

County Hospitals

Counties are authorized to establish and maintain county hospitals and nursing homes. (IC 31-3601 et seq.) Currently, nine Idaho counties own hospital facilities. Idaho Code allows a county commission to appoint a county hospital board, "charged with the care, custody, upkeep, management and operation of all property belonging to the county" (IC 31-3607) which is responsible for conducting, operating and maintaining a county hospital. (IC 31-3601). Basically, county hospital boards are established as a separate public entity to operate and manage the county's hospital assets. The commissioners appoint board members, approve the hospital's budget on an annual basis and one commissioner sits as a member of the hospital's board. A county hospital board is a taxing unit under Idaho law and may levy taxes to support the hospital's operations, although most in Idaho do not.

IHA Members by Ownership

22	Not-for-Profit
9	County
11	Investor Owned
6	District
2	State
1	Federal

Hospital Districts

Idaho currently has six district hospitals charged by Idaho Code with ensuring the "betterment and protection of the public health and care of the sick and afflicted." Hospital districts are established through a process of approval that includes a vote of county commissioners, then approval by a majority of voters in the proposed district. (IC 39-1318 et seq.). Hospital districts may cover more than one county but must be approved by the county commissions of each county. Hospital district boards are made up of seven elected trustees who can appoint up to two additional members if needed. The board members are elected to six-year terms and annual audits are published for the public. Although a hospital district is a separate public entity and has the ability to levy and collect property taxes, these are limited to .06% (less in some circumstances) of market value on taxable property within the district. Any additional levies must be approved by two-thirds of electors.

Private or Investor-Owned Hospitals

The profit or loss of the hospital is a direct profit or loss for the shareholders (owners) of the hospital. These facilities may be publicly traded or privately owned. In the IHA membership, twelve hospitals are investor-owned. These hospitals pay taxes on hospital property and purchases. Specialty hospitals are often private or investor-owned and are licensed facilities that provide a limited service for one of the following types of care: surgical; long-term acute care; psychiatric; or rehabilitative.

State and Federal Hospitals

The Department of Health and Welfare operates Idaho's two state hospitals while the federal government operates Idaho's Veterans Administration Hospital.

System Hospitals

These are hospitals that may be managed or owned by a corporate entity. A hospital system may have a collection of all the hospitals previously described such as for-profit, not-for-profit, specialty or critical access. Additionally, a hospital system may also own or operate other service lines, like outpatient treatment centers or primary care practices.


HOSPITAL OWNERSHIP
County
Not-For-Profit
Federal
District
Investor Owned
State
Boundary Community Hospital
Bonner General Health
Rehabilitation Hospital of the Northwest
Kootenai Health
Shoshone Medical Center
Northern Idaho Advanced Care Hospital
Benewah Community Hospital
Gritman Medical Center
Clearwater Valley Health
Idaho State Hospital North
St. Joseph RMC
St. Mary's Health
Syringa Hospital & Clinics
Lifeways Hospital
VA Medical Center
St. Luke's Nampa Medical Center
Intermountain Hospital
St. Luke's Rehabilitation
St. Luke's Meridian Medical Center
St. Alphonsus RMC
St. Alphonsus Medical Center Nampa
St. Alphonsus Regional Rehabilitation Hospital
St. Luke's Boise Medical Center
Cottonwood Creek Behavioral Hospital
Vibra Hospital of Boise
Steele Memorial Medical Center
St. Luke's McCall Medical Center
Cascade Medical Center
Weiser Memorial Hospital
Madison Memorial Hospital
Teton Valley Health Care
Lost Rivers Medical Center
Eastern Idaho RMC
Idaho Falls Community Hospital
Valor Health
St. Luke's Wood River Medical Center
Bingham Memorial Hospital
Idaho State Hospital South
North Canyon Medical Center
West Valley Medical Center
Power County Hospital
Portneuf Medical Center
St. Luke's Elmore Medical Center
St. Luke's Jerome Medical Center
Caribou Medical Center
Minidoka Memorial Hospital
St. Luke's Magic Valley Medical Center
Bear Lake Memorial Hospital
Cassia Regional Hospital
Nell J. Redfield Memorial Hospital
Franklin County Medical Center

Hospital Governance

The world of healthcare is complex and constantly changing. To ensure the needs of each community are considered and high-quality care is provided, a knowledgeable, committed hospital board is vital. Every hospital has some level of community governance, whether it be through an advisory board, elected trustees, community volunteers or a mix of elected officials and volunteers. The role of hospital board members is to provide governance and leadership to all activities of the hospital. Members are typically a collection of physicians and community leaders skilled in finance, business, fundraising, investment, planning and law, using their knowledge to help the hospital achieve strategic goals.

The roles and responsibilities of the governing board involve everything from ensuring the cost-effective utilization of resources to determining the organization's mission and establishing a long-range strategic plan. Although the responsibilities vary, the primary duties of hospital governing boards include:

- Hiring and retaining an effective CEO
- Developing mission, programmatic and financial strategic planning
- Monitoring and ensuring quality care
- Safeguarding the financial health and viability of the hospital
- Overseeing medical staff credentialing

Trustees are responsible for performing these activities within all applicable licensure standards, relevant laws, and governmental regulations.

Hospital Operations

At its core, every hospital strives to provide quality healthcare for their communities. They are always there, ready to care. To make that clear and concise goal a reality, hospitals, even Idaho's small rural facilities, are multifaceted entities, providing a wide range of services through highly educated and skilled employees and partners. These myriad services are paid by both the direct recipients of care as well as third-party payers – insurance companies, Medicare, Medicaid, Workers Comp, Tri-Care, or the Veterans Administration. Each of these organizations negotiates a unique contractual arrangement or fee schedule with hospitals. That complexity is compounded by an intense level of data reporting, the need to operate a financially viable business that is open 24/7, 365 days a year, and recruiting and retaining highly skilled employees. Simply put, hospitals are unlike any other organization, and running a hospital at the executive and board levels requires a significant amount of knowledge, experience, and understanding of the intricate world of healthcare finance.

At the most fundamental level, hospitals measure their fiscal health by their ability to remain viable and provide services to patients in their communities. A more accounting-based measure is the use of the operating margin. The operating margin is the difference between net operating revenues and the hospital's operating expenses.

As discussed in other sections, hospitals incur costs in providing healthcare services, some of which are not paid. This can occur for various reasons, and some are out of the hospital's control (e.g., fixed reimbursement by governmental payers that pay less than costs or emergency care for the uninsured). Regardless of the cause, these situations present a challenge to a hospital's fiscal health.

Hospitals with positive operating margins can enhance their benefits to the community and charitable care programs as well as invest in technology and capital improvements. Without modern technology and facilities accommodating newer medical procedures, hospitals have difficulty recruiting and retaining physicians, including specialists who have certain expectations to meet the needs of their patients. Positive margins also allow hospitals to weather economic downturns through the use of reserves, much like the state does with its Rainy Day Fund.

Average Operating Margin for IHA Member Hospitals (Hospital Operations)	
FFY 2021	0.97%
Average Operating Margin for IHA Member Hospitals (Hospital Operations)	
FFY 2022	(2.92%)

A hospital's operating margin is calculated by subtracting expenses from revenues. In normal times, the average margin for Idaho's hospitals barely kept pace with inflation. In fact, for Federal Fiscal Year (FFY) 2022, 24 of 27 rural Idaho hospitals ended their year with a negative operating margin. Overall, 76% of Idaho's hospitals had a negative operating margin.

During FFY 2022, Idaho's hospitals had some of their worst financial quarters in decades. Workforce shortages, skyrocketing labor costs, and uncontrolled increases in pharmaceuticals and other supplies – compounded by fixed reimbursement rates from government and commercial payers – created a massive and unsustainable swing in operating margins for hospitals.

Because of the nature of governmental reimbursement and uncompensated care, our hospitals must rely on other sources of revenue to achieve modest margins (especially by normal business standards). Consider, for example, a somewhat comparatively regulated and vital public entity like Idaho Power. In its 2023 annual report, Idaho Power had a net income of approximately 14.8%.

The long-term effects on operating margins caused by less-than-cost governmental reimbursements have yet to be adequately addressed and continue to worsen. It is critical that we resolve issues like compensation for the care delivered, reducing burdensome and duplicative reporting, creating a healthcare system where care coordination improves the care for the patient and reduces waste, and addressing the needs of the uninsured and underinsured so they are able to get appropriate care in the right setting before problems become severe.

Ensuring our community hospitals remain viable and accessible throughout Idaho is critical to sustaining rural communities and allowing Idahoans to find quality healthcare close to home. The most basic and efficient way hospitals can stabilize their financial footing is to have reserves. Regardless of their organizational structure

(not-for-profit, county, district, or investor-owned), hospitals are allowed and expected to keep an appropriate level of reserves. The minimum amount of reserves is expected, by industry standards, to be 90 days of operating cash on hand. For many Idaho hospitals, this is a number that has been difficult to attain and sustain, even before the workforce shortages.

Reserves are necessary to provide resources in times of economic stress or for providing necessary equipment to keep services and providers in the community. Reserves are also essential to establish a hospital's fiscal health when borrowing to replace antiquated buildings or equipment. As a key indicator of fiscal health and viability, reserves are required by financial institutions as a condition for capital lending. Reserves impact the cost of borrowing, and a violation of this requirement can result in the lender demanding immediate repayment or an increased interest rate on the debt.

Patient Billing and Payment

Chances are good that if you get a call from a constituent about healthcare, a confusing bill is likely at the center of it. At the end of the day, one of the most talked about issues is the hospital or provider bill. Billing and payment of claims for members of health plans (private or governmental) is determined by contract terms or by federal and state law. The degree to which hospitals and other providers can negotiate reimbursement from non-governmental insurance varies considerably. As referenced earlier, there are a host of different plan types, provider networks, and reimbursement methodologies.

The healthcare delivery system is a combination of complex organizations doing multi-faceted work designed to get people to a healthy state from countless ailments at varying levels of severity – working to save lives in the process. Throughout this process a bill must be created that goes through numerous iterations beginning with the patient's first steps of care. With so many different fingerprints on a given person's care – including labs, x-rays, rehabilitation, anesthesia, doctors, specialists, and hospitals as well as those determining necessity of care, payment and coverage – the resulting documents can often be overwhelming and confusing. Hospitals have staff available to work with patients throughout the financial process.

Insured patients typically receive two types of documents. Statements – generally received after services are provided but before the insurance company is billed – outline the charges for each service received. These charges are not at the rates agreed upon with the insurance company, which generally means they are not the actual cost that will be incurred by the patient, similar to the way that the sticker price of a new car is rarely what the buyer pays.

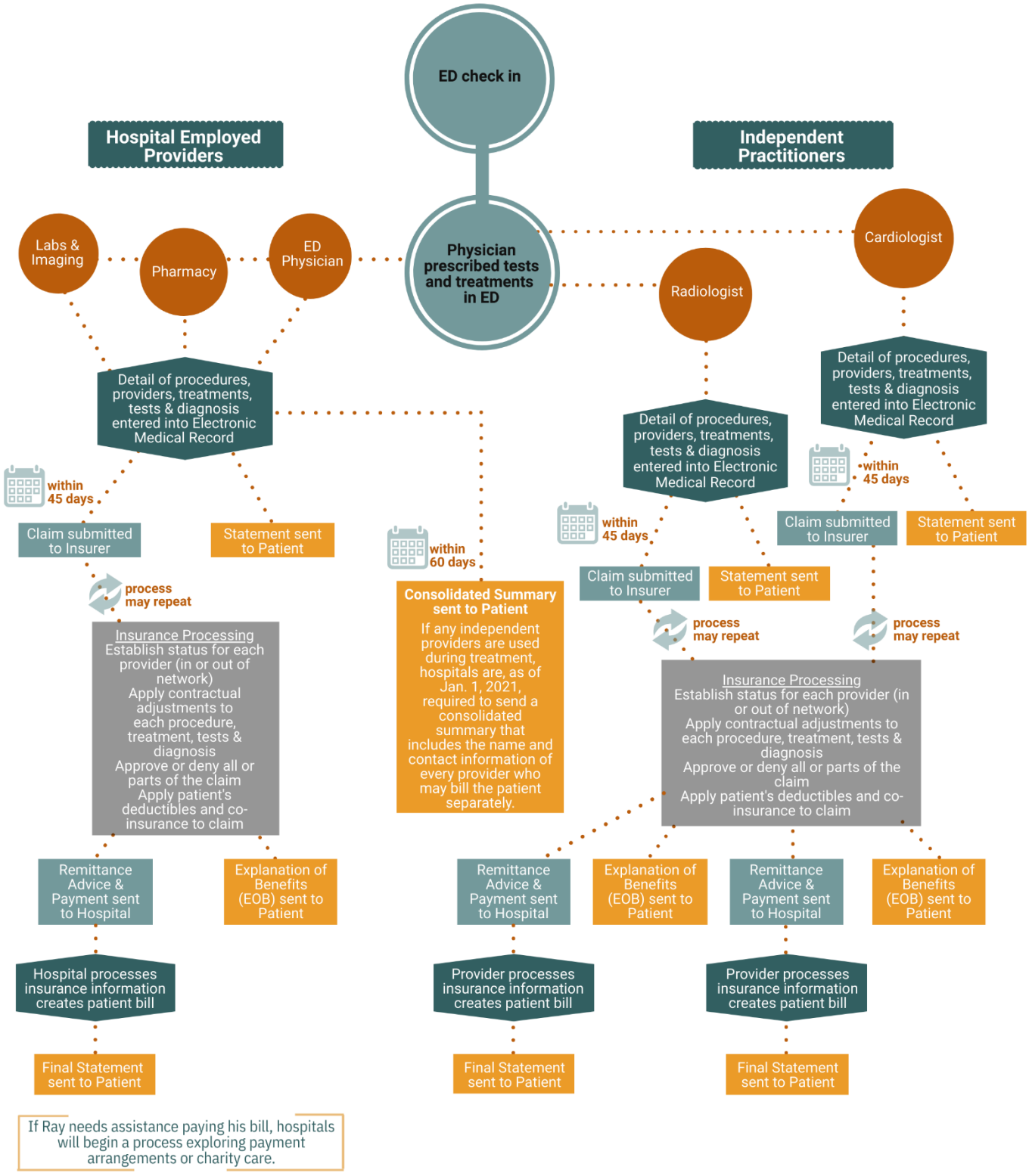
The second item is the hospital bill which is received after the insurance company has reviewed the detailed information they were sent. The bill lists the charges as well as the adjustments reflecting the difference between the charges and the amount the insurance company has negotiated for the services. This is known as a contractual adjustment. That is followed by the amount that will be paid on the patient's behalf by the insurance company which depends on the plan, the provider's network status with the insurance company, and the insured's status with their deductible and/or out-of-pocket costs. Any residual amount left after considering these adjustments would typically be the amount owed by the patient. These amounts may comprise a combination of deductible, co-insurance, co-payments and non-covered charges as determined by the patient's insurance plan.

While hospitals and providers can provide estimates to patients based on the care they expect to receive and what their insurer's contractual amount is, it's important to note it isn't a complete picture of the patient's out-of-pocket costs. Until the insurance process is completed, hospitals don't know how much deductible is yet to be fulfilled by the patient. Additionally, situations that end up needing more complex or different care and treatment than originally anticipated will change the patient's final bill.

No two cases are exactly alike but the following is an example of a simplified billing process a patient might experience after care in the local emergency department. As you can see, even "simplified" is anything but simple.

Ray's Hospital Billing Story

a 50-year-old who experienced severe chest pain and headed to a local Emergency Department with his employer-sponsored insurance coverage.



Healthcare Payers

Healthcare is a unique industry where the consumer (i.e. the patient) does not usually carry all of the financial burden for the services they receive. Insurance and government payers are a significant part of the financial equation. These "third party payers" heavily direct the cost of healthcare as well as acceptable or allowable processes and treatments.

Price Makers & Price Takers

Even though you see the logo of your community hospital on it, the hospital isn't the primary driver that determined what would be on your bill. Hospitals, in economic terms, are mostly price takers – just like you are at the grocery store. When you need eggs, you either buy them at the stated price or not. You don't call over a manager to negotiate a different price. You take the price that is set…or you don't have scrambled eggs for breakfast.

The difference is that a plate of scrambled eggs is a want, but healthcare is a need.

So, who are the key price makers that influence rates and have pricing power?

Pharmaceutical companies ~ With little or no competition for many drugs, pharmaceutical manufacturers are price makers, setting the cost for expensive but necessary infusions, drugs, and other treatments.

Insurers ~ Those that cover our patients – whether it's Medicare, private insurance, or Worker's Compensation – set the prices hospitals and providers are reimbursed.

Workforce ~ Idaho competes regionally and sometimes nationally for key employees like nurses, doctors, specialists, and therapists. Compensation offered by neighboring states directly impacts what we have to pay to keep quality employees, and high demand and lower supply means higher costs.

The impact of these three significant price makers is what drives the bottom line of healthcare costs.

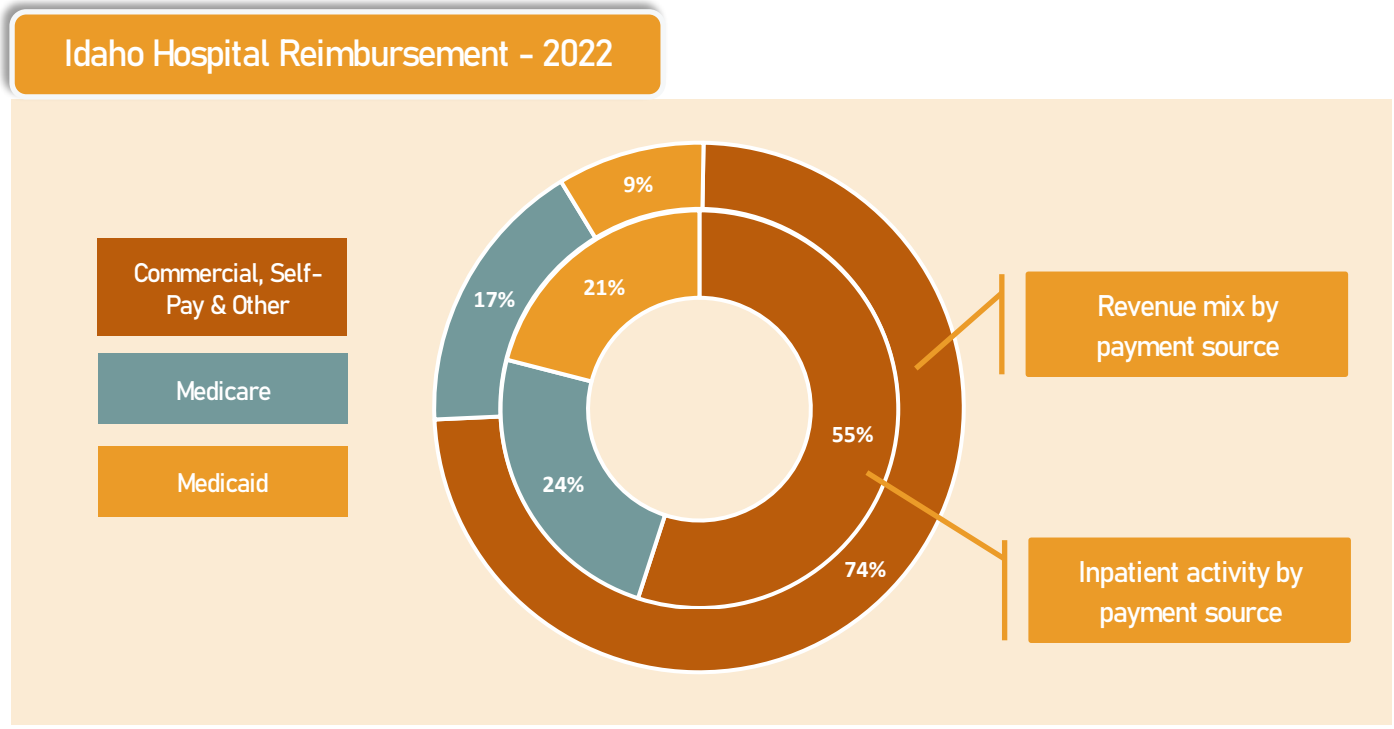
Federal law requires each hospital to charge the same prices to all patients. This list of prices, along with the associated medical codes, is the hospital's chargemaster. While charges are the same regardless of the patient being served, the hospital receives different payment amounts (reimbursement) depending on the payer source. Hospitals negotiate payments for billed charges with some payers and receive predetermined amounts from others. In Idaho, payers fall into three categories:

Private Insurers (commercial, Medicare-advantage (MA), and employer-based) pay rates that are negotiated between the payer and the hospital through contracts, thus creating a network of providers offering health services to patients who are insured by a particular health plan.

Government payers pay the lowest rates which often do not cover the actual cost of the service. Types of government payers include, but are not limited to, Medicare, Medicaid, the U.S. Department of Veterans Affairs, Department of Defense, and state correctional agencies.

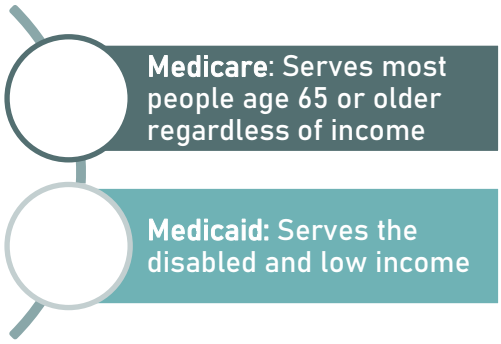
Uninsured or underinsured patients have either no insurance coverage or plans with large deductibles or limited coverage. They can also be considered "self-pay".

The chart below depicts how the largest payers (commercial, Medicare, and Medicaid) impact hospitals reimbursement in Idaho in contrast to the rate their enrollees access inpatient services.



Governmental Payers

For hospitals, or any other provider, to receive payments from Medicare or Medicaid, they must first go through a rigorous certification process and adhere to the Conditions of Participation (CoPs).



Hospitals are also classified into one of three hospital types for payment: Prospective Payment System (PPS), Critical Access Hospital (CAH), or Rural Emergency Hospital (REH). Payments are further classified by service type: inpatient hospitalizations and outpatient procedures, diagnostics, or treatments. Each type of payment has its own reimbursement methodology and those differ between the types of hospital (PPS / CAH / REH).

Like commercial insurance, hospitals and other healthcare providers are paid by Medicare and Medicaid only after services are provided to the beneficiary.

Medicare

Established in 1965, Medicare is available to most people beginning at age 65 and to those with end stage renal (kidney) disease or total disability. Medicare is funded by a combination of contributions made by employers and their employees while the employee is working, premiums paid by Medicare participants, and federal funds. In May 2024, 390,132 Idahoans (or 19% of Idaho's population) were covered by Medicare. This is a six-percent increase from 2022.

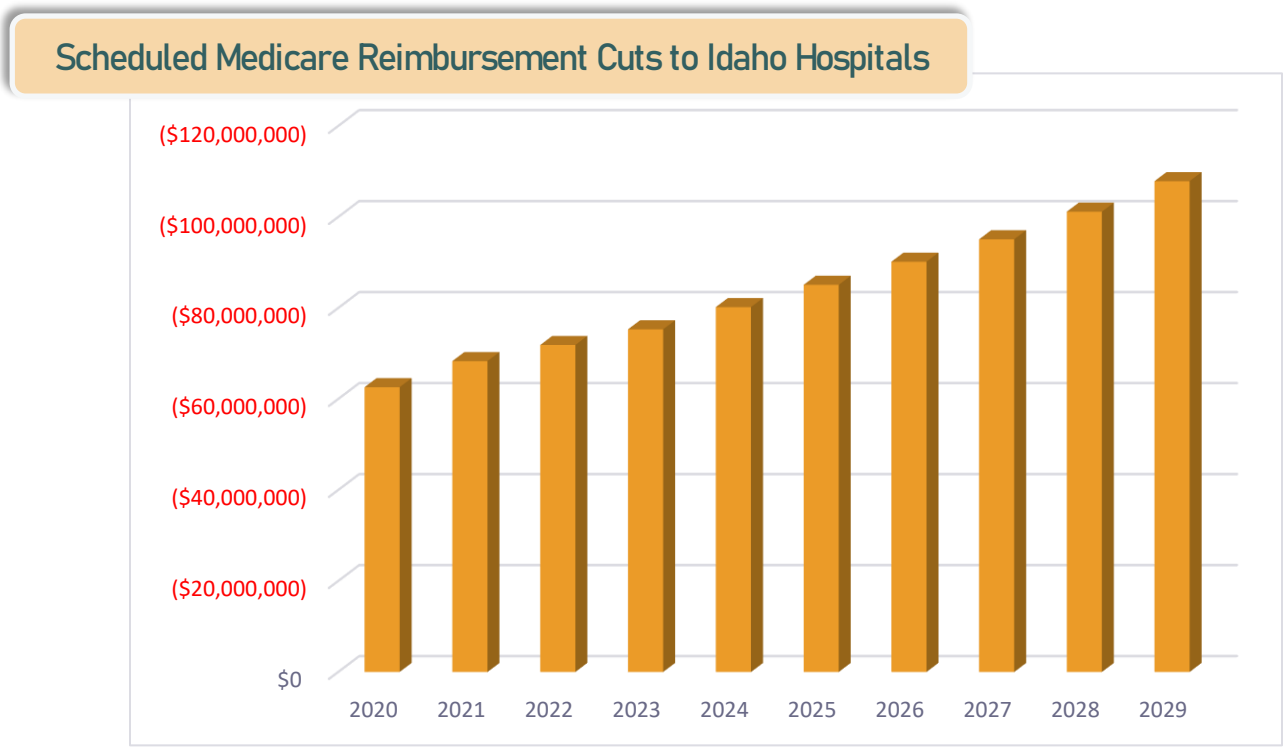
Medicare is made up of:

- Part A, which covers hospital benefits
- Part B, which covers outpatient and physician services
- Part C, an option to receive Part A, B and sometimes D benefits through private insurance plans known as "Medicare Advantage" plans. These plans can include enhanced benefits at additional costs (i.e. vision or lower co-pays)
- Part D, Medicare's prescription drug plan

Medicare is overseen at the federal level by the Centers for Medicare and Medicaid Services (CMS) and is administered through contractors known as Medicare Administrative Contractors (MACs). Idaho's MAC is Noridian Healthcare Solutions.

Medicare payments vary among geographic regions to reflect local wage rates (aka the Wage Index). Idaho hospitals are reimbursed at lower rates than neighboring states like Washington and Oregon. Our state's lower Wage Index negatively impacts hospitals' ability to recruit much needed employees as we are not reimbursed as high as our regional counterparts.

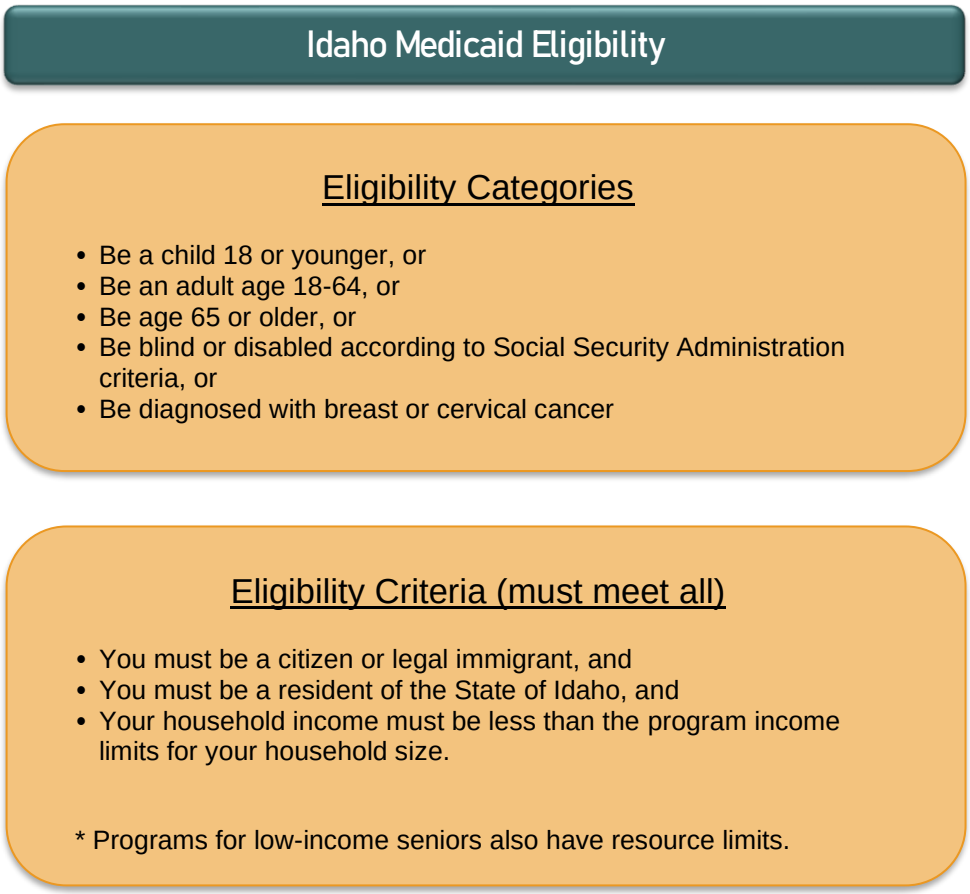
Overall, Medicare pays less than cost to most hospitals and this trend is scheduled to become exacerbated. Since 2010, Idaho hospitals have had Medicare reimbursements cut by over $995 million. An additional $634 million in cuts are scheduled from 2023-2029. Some of these cuts come from the Affordable Care Act and were designed to offset the cost of paying for coverage of the uninsured through Medicaid expansion. These cuts to Idaho hospitals began in 2010 and have happened regardless of Idaho delaying expansion of Medicaid until 2020.



Medicaid ~ Eligibility and Coverage

Established in 1965, Medicaid is available to the lowest-income individuals, pregnant women, and the aged, blind, or disabled. Jointly funded by the federal and state governments, the program is operated by the states and overseen at the federal level by the Centers for Medicare and Medicaid Services (CMS). Idaho's Medicaid program is administered by the Department of Health and Welfare in accordance with a contract between CMS and the State of Idaho known as the State Plan.

Although the federal government sets minimum standards, Idaho, as well as all other states, has some level of flexibility in designing the eligibility and services that can be provided through the Medicaid program. States can elect to cover people at higher income levels and define additional eligible populations. Eligibility for Medicaid is assessed both by category and criteria as can be seen in the following chart.

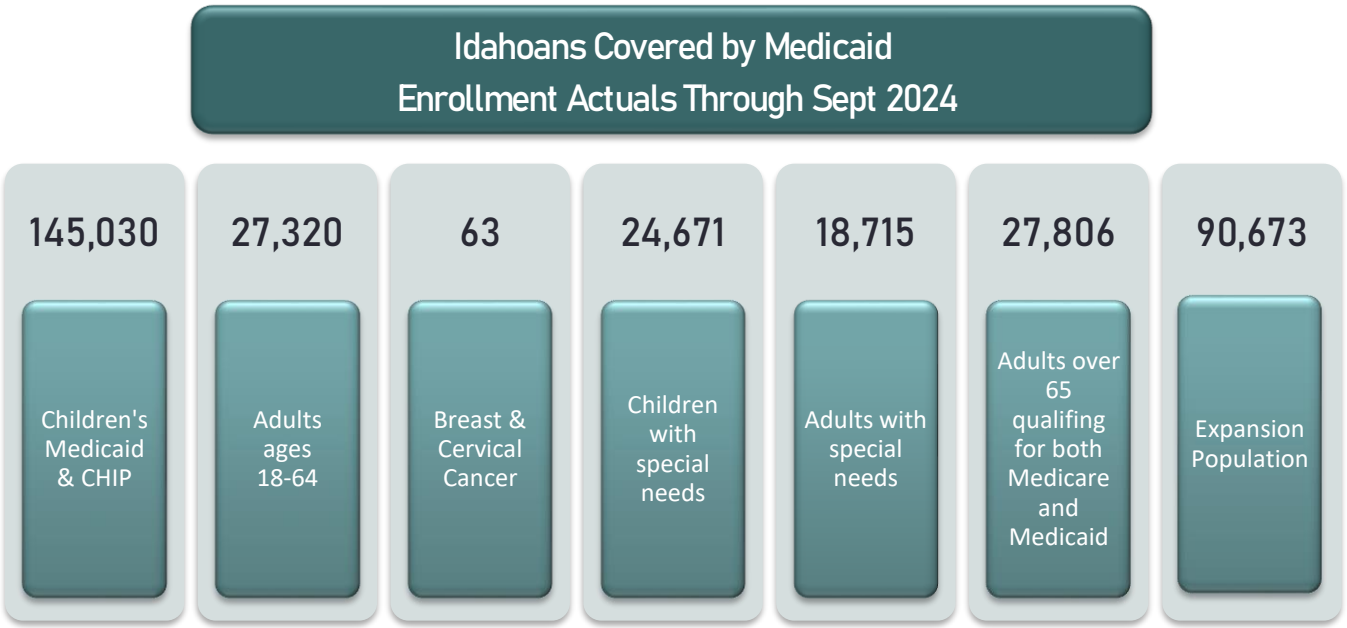


Medicaid programs are available for different populations including children, expectant mothers, adults, and seniors. Each program has its own income criteria based on the size of the household. For low-income seniors who are also on Medicare, sometimes referred to as “Dual Eligibles”, there are also thresholds for their resources. The income limits are a factor of the federal poverty level (FPL).

Medicaid Maximum Monthly Income Limits – Effective Jan. 2024

This chart does not apply to disabled adults or children, women with breast or cervical cancer, or those who are eligible for dual coverage under Medicare and Medicaid

Household size	Monthly Income for Coverage of Child Under 19	Pregnant ~ Monthly Income for Adult Coverage *(unborn child counts as part of household)*	Adult
1			$1,732
2	$3,237	$2,351	$2,351
3	$4,089	$2,970	$2,970
4	$4,940	$3,588	$3,588
5	$5,792	$4,207	$4,207
Each additional	+ $852	+ $619	+ $619



Data provided by Idaho Department of Health and Welfare

Medicaid Funding

Idaho's Medicaid administration is highly efficient, with nearly 97 cents of every dollar being spent to provide healthcare services. Even with that efficiency, providers are not reimbursed for the actual cost of providing the care.

Federal law dictates that Medicaid cannot pay more than what Medicare would have paid for the same service. Where Medicare has fee schedules, for example outpatient radiology and lab services, the fee schedule has been deemed by CMS to be the "allowable cost" for Medicaid reimbursement. However, those fee schedule rates are often lower than the hospitals' actual costs. Overall, when you factor in all Medicaid payments as well as supplemental payments, hospitals report receiving between 90% – 93% of the cost to provide care.

Idaho Medicaid currently pays under a cost-based, fee-for-service design; however, under legislative direction, the Department of Health and Welfare is working with providers to move toward a value-based reimbursement system. The foundations for this evolution are the State Health Innovation Plan (SHIP) and the development of Patient-Centered Medical Homes (PCMH) across the state.

Medicaid is jointly funded by the federal and state governments. In the existing Medicaid program, the federal government provides about two-thirds of the funding while Idaho pays the remaining portion. For the expanded Medicaid program, Congress has statutorily set the split at 90% federal funds and 10% state funds.

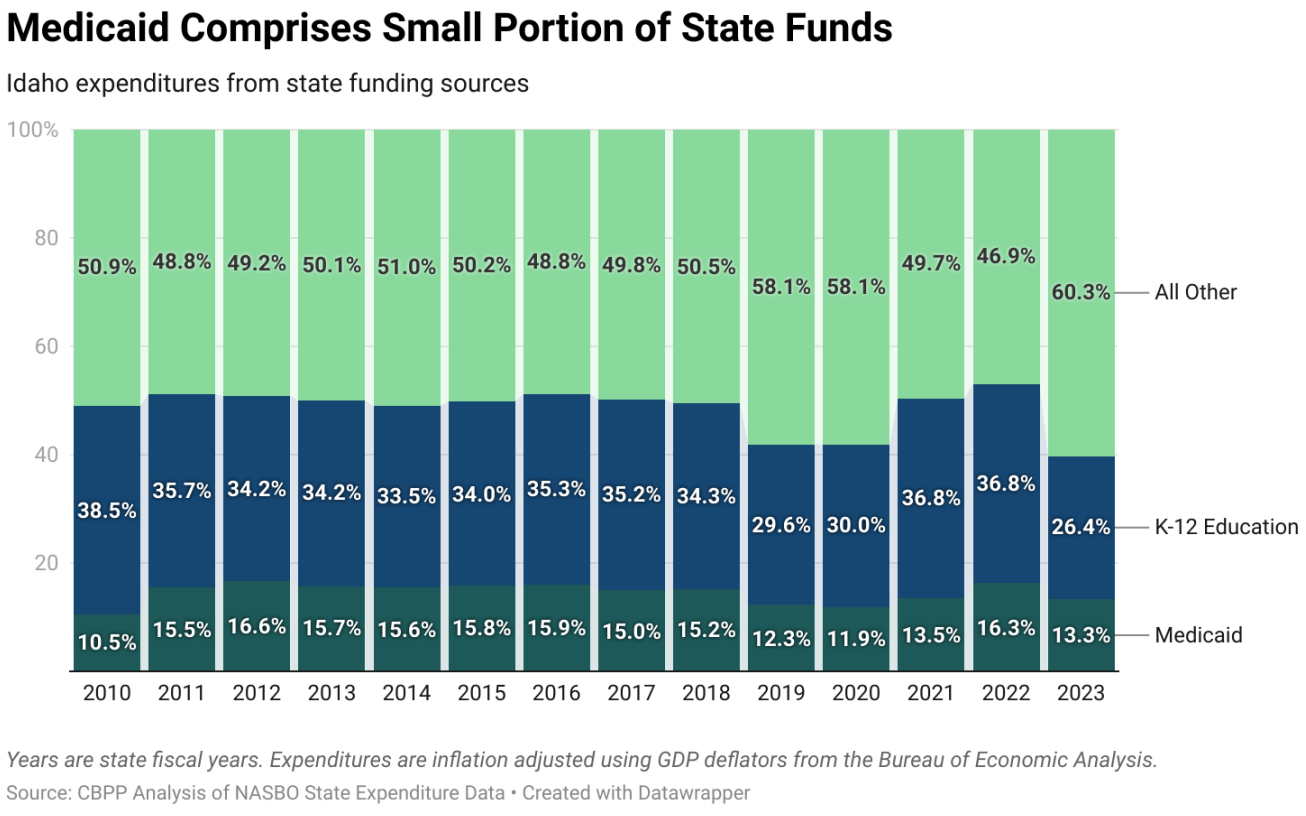
Although the Medicaid expansion program exceeded its projected costs in the first year, it was still a windfall to the state and local communities, contributing heavily to an almost two-billion-dollar surplus. In addition to savings to local and state government programs, Medicaid expansion allowed for budget reductions for the Department of Correction, Division of Behavioral Health, State Catastrophic Fund and a shift for Public Health costs to counties that no longer had to pay for County Indigent Programs. Medicaid expansion generated additional economic activity throughout the state and put money back into the state and local coffers, supporting tax rebates and record investments in schools, infrastructure, and workforce development. While Medicaid expansion enrollment fluctuates monthly, providing healthcare coverage for 81,553 Idahoans (November 2024) allowed many of those enrollees to stay in the workforce.

Federal Share – The federal share (often referred to as the match) is called the Federal Medical Assistance Percentage (FMAP) and the exact amount is determined annually by the Centers for Medicare and Medicaid Services (CMS) based on each state's per capita income; the lower the per-capita income, the higher the FMAP. Simply stated –

the more Idahoans earn, the more responsibility we have for the cost of Medicaid. As one of the states with the largest growth in per capita income, federal participation in Idaho's traditional FMAP has decreased to 66.91% (IDHW projection) for Federal Fiscal Year 2025.

Some Medicaid programs, such as the Children's Health Insurance Program (CHIP), Tribal Healthcare, as well as Idaho's expanded Medicaid program have enhanced match rates that are statutorily set by Congress. The Medicaid expansion program is set at a 90/10 match rate regardless of economic indicators. That rate cannot change without a specific act of Congress.

State Share – The state share for Medicaid is funded through the Idaho Legislature's annual appropriation process. Even with the addition of Medicaid expansion, the percentage of the entire state general fund allocated for Medicaid costs has stayed relatively stable, averaging less than 15% of the total general fund budget since 2010.



Years are state fiscal years. Expenditures are inflation adjusted using GDP deflators from the Bureau of Economic Analysis.

Source: CBPP Analysis of NASBO State Expenditure Data • Created with Datawrapper

Supplemental Payments

Because hospitals do not receive sufficient payment to cover the costs of serving Medicaid, Medicare, and uninsured patients, some hospitals are eligible for special supplemental payments through the Medicaid Disproportionate Share Hospital Program (DSH), Medicare DSH Program, or Medicaid Upper Payment Limit Program (UPL). The Disproportionate Share Hospital (DSH) program is a state Medicaid payment program that allocates an annual federal DSH allotment. The Medicaid DSH Program provides hospitals financial assistance toward the cost of care for the uninsured and any remaining uncompensated Medicaid costs (after UPL payments are considered).

Medicaid DSH and Upper Payment Limit (UPL) Hospital Programs

Generally, to qualify for a DSH payment in Idaho, a hospital must meet the federal criteria of having at least a one-percent Medicaid utilization rate and have an ongoing capability to do non-emergent delivery of newborns. Once eligible for DSH, the amount of DSH funds paid to a hospital depends on the burden of uncompensated Medicaid and uninsured care relative to other eligible hospitals. It is also dependent on the amount of federal funding made available to the state in the annual DSH allotment. In 2022, the federal DSH allotment for Idaho was $7.9 million (down from $21.2 million in 2021). The reason for the significant decline was the change in Medicaid reimbursement methodology which caused the UPL to increase and the available DSH allotment to decrease. Idaho is categorized as a "low DSH state" as the state's Medicaid DSH payments account for less than 1% of all Medicaid spending. State Medicaid DSH payments that are above the 3% threshold are considered "high DSH states". In some of these states, DSH payments can account for nearly 17% of total Medicaid spending.

Certain hospitals qualify for supplemental payments to help subsidize regular Medicaid payments that are less than the federally regulated UPL (Upper Payment Limit). These payments are calculated and paid at the end of the year and are in addition to regular Medicaid payments. The UPL is a federally required calculation that the state Medicaid program must present to CMS annually. Federal regulation requires that Medicaid cannot pay hospitals more than Medicare would have paid, had Medicare been responsible to pay for hospital services. Once the state proves to CMS' satisfaction that Medicaid paid out less than the federal UPL ceiling, the state is allowed to disperse federal supplemental payments to providers to reach that UPL ceiling through an approved payment methodology.

The state must provide matching funds for both the annual federal DSH allotment and UPL payments. The state's share is based on the state's FMAP rate. In Idaho, hospitals provide the state matching funds via hospital provider assessments on private hospitals or intergovernmental fund transfers from non-state government-owned facilities. By calculating the DSH payments after the UPL distributions have occurred, the state Medicaid program ensures that there is no "double dipping" from these two supplemental payment programs.

It is important to note that despite these supplemental payments, hospitals still are not paid adequately to provide care to the Medicare and Medicaid populations. Further, DSH funding has been cut significantly beginning in 2021 as part of the Affordable Care Act. Moreover, with the CMS approval of Idaho's application to adjust the payment methodology for the Upper Payment Limit, it is likely the DSH payments will disappear altogether.

2022 Hospital Tax Increase

In the 2022 Session, the Idaho Legislature amended the Hospital Assessment Statute to allow for a new calculation methodology that would increase the Federal supplemental payment to hospitals that helps offset losses incurred from lower state Medicaid reimbursement rates. The new methodology was approved by CMS in December 2022. This amendment allows the state to tax hospitals up to 30% of that total payment to offset other non-hospital Medicaid expenses, including home and community-based services (HCBS) to allow developmentally disabled adults to stay in their homes and communities. However, the state match required to draw down this federal payment is still provided by hospitals themselves, not the General Fund.

Workers' Compensation

In Idaho, state law requires that any employer with three or more regular employees have workers' compensation coverage for disability, rehabilitation and medical care for a worker that is injured on the job. Idaho law allows employers to require injured employees with a non-emergent condition to obtain treatment from designated providers as long as the employer has followed state law regarding notice of the providers. Insurance companies authorized to write workers' compensation insurance in Idaho are required to abide by the rates set by the National Council on Compensation Insurance (NCCI).

While Workers' Compensation is highly regulated by state law, the coverage for disability, rehabilitation and medical services is typically provided by property and casualty insurance companies or self-insured employers. Coverage of an injured worker's care may be contingent on both the employee and the employer following the rules promulgated by the Idaho Industrial Commission which publishes a fee schedule that sets the rates for hospital and physician payments. Inpatient payments depend on the patient's diagnosis and treatment, much like Medicare rates.

Private Health Insurance Coverage

Health insurance plans are regulated by both state and federal law. The 2010 Patient Protection and Affordable Care Act (ACA) made sweeping changes to the health insurance industry and imposed a number of requirements intended to control cost and expand the availability and quality of health insurance to consumers.

Regardless of the ACA, an insurance company in the United States must be licensed by the state in which it issues coverage. It is possible for an insurer to issue coverage in one state that covers members that live in another. The Idaho Department of Insurance is responsible for licensing companies to transact business in Idaho and for ensuring that those companies remain solvent and comply with all the requirements of Idaho laws and regulations. Currently, eight companies are authorized by the Idaho Department of Insurance to offer individual market health benefit products in Idaho.

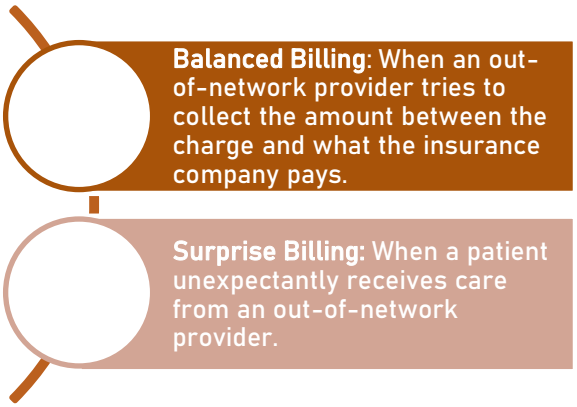
The majority of health insurance offered in the United States today is considered "managed care." The term managed care generally means a system for financing and, sometimes delivery, of healthcare that is intended to control cost, utilization and quality of care. For plans licensed in Idaho, there are a number of state regulations that address the way they can do business, including the time within which the plan must pay claims, late payment interest and rules related to authorizations for services and appeals. There are many types of managed care plans although the distinction between types has become more and more blurred over the past few years. All tend to share common characteristics to varying degrees, including:

- Networks of contracted providers that agree to accept reduced rates for services in exchange for an expected higher volume of patients or the ability to have coverage for patients in some plans.
- Requirements for prior authorization of many services.
- Tiered cost share amounts for prescription drugs.
- Scrutiny of medical necessity of care.
- Payment policies that may dictate the setting or other prerequisites for coverage of some services.
- Variability in the patient's share of cost for healthcare services, such as:
    - Is the provider in the plan's network? Some plans may have no benefits for providers not in the network. When covered, cost share amounts are typically higher for lower tier or out-of-network providers.
    - What type of service is being provided? Regardless of network participation, state and federal law require that emergency care be covered. The ACA requires that specified preventive care be covered in full when provided by in-network providers.

In recent years, the trend has been toward significantly increasing patient cost share amounts for both in- and out-of-network care to the point that the financial responsibility has become unaffordable for many patients and contributes to higher hospital bad debt.

For providers in a network, the patient can be billed only for the patient's cost share amount (copayments, coinsurance and deductibles) and for services not covered by the plan, regardless of the "allowed amount" determined by the insurer (which should be consistent with the provider's contract rate). The provider is often required to obtain the patient's consent prior to rendering non-covered services in order to bill for them.

When a provider is not in the plan's network, of course, there is no contract to dictate the amount that the plan must pay or the amount that can be billed to the patient. Many insurers will set the allowed amount at what they consider to be a "reasonable" fee for the service(s) received when making payment. This will leave the patient with a greater liability to the provider than if an in-network provider was used. Additionally, the plan can, and often does, assess significantly higher deductibles and co-insurance amounts when out-of-network providers are used.



However, federal law prohibits the increasing of co-insurance and deductible amounts when accessing emergency services in out-of-network hospitals.

"Balanced billing" occurs when an out-of-network provider bills the patient for the amount between the charge and the insurer's allowed rate.

On Dec. 27, 2020, the No Surprises Act was signed into federal law, addressing surprise medical billing. In part, this law, much of which went into effect on January 1, 2022:

- Protects patients from receiving surprise medical bills resulting from gaps in coverage for emergency services and certain services provided by out-of-network clinicians at in-network facilities, including by air ambulances.
- Holds patients liable only for their in-network cost-sharing amount, while giving providers and insurers an opportunity to negotiate reimbursement.
- Allows providers and insurers to access an independent dispute resolution process in the event disputes arise around reimbursement. The legislation does not set a benchmark reimbursement amount.
- Requires both providers and health plans to assist patients in accessing healthcare cost information.

In addition to the federal No Surprises Act, Idaho passed the Idaho Patient Care Act creating mandates for hospitals and healthcare providers regarding the patient billing process and medical debt collections.

Types of Plans

The major differences between the most common types of plans are:

Preferred Provider Organization (PPO) plans do not require separate licenses in most states although the insurers that use PPOs for their benefit plans must meet licensure requirements. Typically plan rules are not as stringent for PPOs as for HMO plans and out-of-network care is usually, but not always, covered.

Health Maintenance Organizations (HMO) are separately licensed and generally have higher financial reserve requirements than other plans. HMOs often have closed provider networks which means that, except for emergency care, services are covered only when rendered by providers within the HMO network. HMOs may also require that a covered person have a primary care provider coordinate their care.

High Deductible Health Plans (HDP or HDHP) combine a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) with medical coverage that has higher deductibles than traditional insurance plans. The HSA or HRA may be funded by either employer or employee contributions or both and are designed to encourage patients to be better consumers of care.

Medicare Advantage Plans (MA) are plans offered by private insurance companies that follow Medicare rules.

Your Health Idaho - Health Insurance Exchange

As a requirement of the ACA, most U.S. citizens and legal residents were required to have health insurance beginning in 2014, although there is no longer a financial penalty for individuals who do not carry insurance. In Idaho, residents can purchase insurance coverage through the state-operated insurance exchange, Your Health Idaho. Individuals or families with incomes between 139% and 400% of the federal poverty level who purchase coverage through Your Health Idaho are eligible for tax credits, which will help offset their premium costs.

In 2023, 99,000 Idahoans enrolled in coverage through Your Health Idaho. For 2023, Your Health Idaho consumers had access to 141 medical and 21 dental plans offered by twelve different insurance carriers. Although not all insurers offer their products in all counties, every Idaho county had at least three insurers offering plans through the exchange. All plans are offered by insurance companies licensed in Idaho. All plans are required to offer the same set of essential health benefits but may have different networks of

providers. Plans are classified into five categories: Platinum, Gold, Silver, Bronze, and Catastrophic. Plan designs differ by the premium and the percentage of healthcare costs paid by the consumer.

Self-Insured Employee Benefit (ERISA plans)

In the United States, about two-thirds of the people who are not covered by government programs obtain their healthcare coverage through an employer. Employers that offer health benefits may either purchase insurance from a licensed insurer or set up their own plans in accordance with state and federal law. The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry. The motivation behind ERISA is to provide uniform oversight under a set of national standards for employee benefits. Prior to the passage of ERISA, self-insured employee benefit plans were governed by state insurance laws. Employers complained of the high administrative costs associated with maintaining plans that were subject to the laws of multiple states.

To make the regulation of these plans consistent throughout the country, ERISA preempts state laws that "relate to" employee benefit plans. Whether a law "relates to" an employee benefit has been a frequent subject in federal court. ERISA does not cover benefit plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable worker's compensation, unemployment, or disability laws. ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans.

Under self-insured employee benefit plans, the employer or employer organization funds the plan but may have a Third-Party Administrator (TPA) or an insurer provide the provider network, care management services and claims processing. For an insurer, this is referred to as "Administrative Services Only" or ASO business. This can be confusing to hospitals because it is difficult to tell whether a patient is covered by a fully insured or an employer-funded ERISA plan. The reason this is important is that state law and the plan's rules, including payment policies, may vary significantly between the different types of plans.

Hospital Economic Impact

Clearly, a hospital's primary role is to improve and sustain the health and well-being of the communities they serve. Hospitals are there to provide the care you or a family member might need; are instrumental in emergencies; and, are a community health resource. They address and meet needs many don't even know about until they are faced with an accident or illness.

There is another benefit healthy hospitals bring to their communities. Throughout Idaho, hospitals are economic drivers providing good jobs in a sector with evolving opportunities across several career paths.

In 2023, your community hospitals employed:

34,957 people

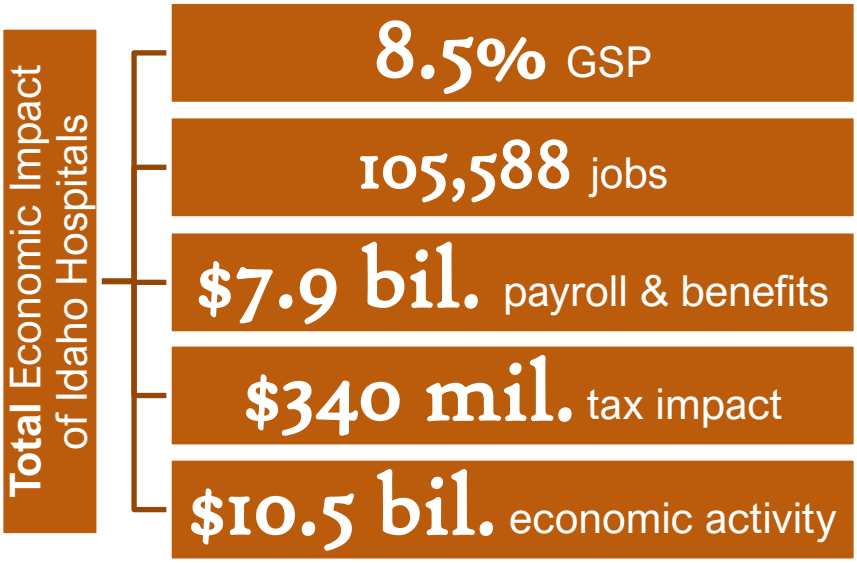
Those employees received combined payroll and benefits worth:

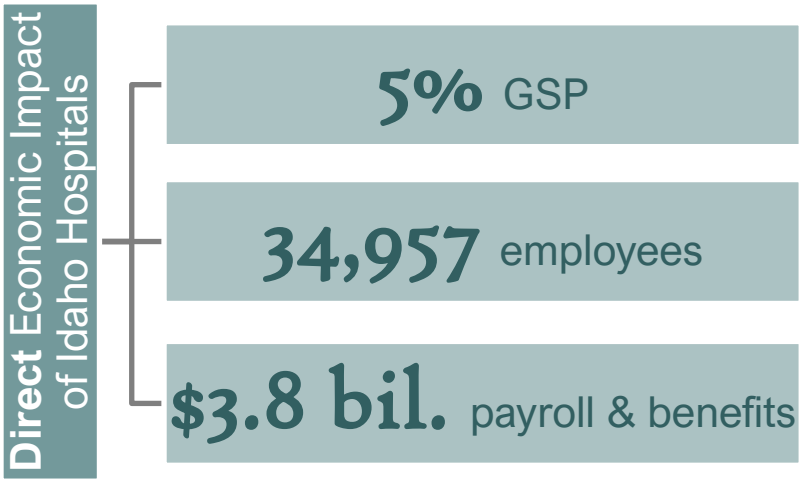
$3.8 billion

Hospitals are a major economic engine for Idaho and considered key to the state's efforts to recruit and retain new and expanding businesses. The impact hospitals have doesn't end with good jobs. Industries and organizations often look at the overall economic impact they have locally or regionally. The impact model measures their ability to draw in new dollars to the defined economy (in this case Idaho's state economy) as well as the impact of dollars spent within the region. In 2023, Idaho's hospitals accounted for about 8.5% of Idaho's Gross State Product (GSP) when the economic impacts are measured.

Like all other businesses, Idaho's hospitals spend money to operate. Measuring these dollars is considered a "direct effect". The dollars also have downstream impacts throughout the economy on services, sales, payrolls, jobs, and taxes – the indirect and induced effects. When economists measure the total impact a given industry or business has on the local economy, they use the data to create a multiplier which measures the impact by taking into account the direct, indirect and induced effects. These multipliers are unique to the industry and to the local economy.

Considering the multiplier effect**, hospitals generated over $10.5 billion in economic activity**. Every $1 of hospital expenditures resulted in $1.81 of economic activity (or impact). That activity leads to the support of jobs outside of the hospitals, impacts on state and local taxes, and the purchase of local goods and services.





Property Taxes

Hospitals pay property tax, even non-profit hospitals. Property not being used for hospital services is not automatically exempt from property taxes. There is a misconception that once a hospital employs a physician or purchases a medical practice, their office space comes off the tax rolls. In the majority of cases, ownership of the property remains the same and the hospital simply leases that space. Thus, property taxes are still paid on the property. Exemptions are applied for annually and approved or rejected by the county assessor.

Community Benefit

Because health is about more than the treatment of sickness or disease, hospitals reach out to their communities with programs and services that address community health needs and preventative care. Hospitals look at both short-term and long-term health improvement, supporting healthy living, access and coverage, and quality of life. Health screenings, clinical services, support groups, research, education, subsidized health services, in-kind contributions, and the provision of charity care are just a few instances of how hospitals go above and beyond their mission to improve the health of their communities.

Idaho hospitals put millions of dollars into healthcare education, underwriting opportunities for prospective doctors, nurses, medical technicians and clinicians to attend school and hopefully work in their communities after graduation. This support has been critical to address both the healthcare workforce shortage as well as the needs of a rapidly growing and aging population.

In 2022, Idaho hospitals cumulatively provided over **$78 million in charity care** (an 18% increase over 2021). This is calculated based on the actual cost to provide that care and is provided to patients who typically do not have insurance, are underinsured (have high-deductible plans) or meet other hospital charity care policies. In these cases, the hospital covers all or part of the patient's bill.

It's important to understand that charity care, as defined by federal guidelines, is usually requested or applied for early in the healthcare process. Patients and hospital staff discuss the situation and complete the needed documentation to qualify for the hospital's charity care program.

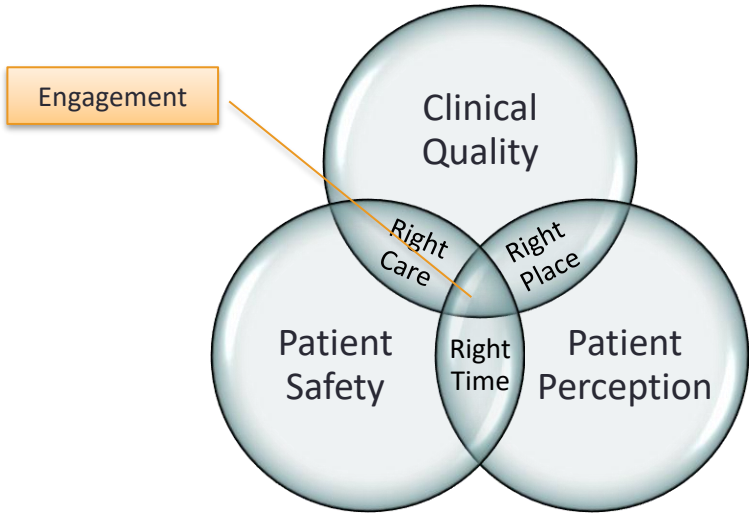
Remember that a hospital cannot, under federal law, refuse to treat a patient who arrives at the emergency department. All patients must be given care, regardless of their ability to pay. Unfortunately, the Emergency Department is very often the place that sees patients who do not have insurance or financial resources, and with a medical problem that could have been treated early or prevented that has created an urgent situation. Emergency Departments, while a great community asset and good stewards of their resources, are often the most expensive place to receive treatment.

If the hospital is not informed or made aware of a patient's financial situation and care is provided, the hospital will send the bill with the expectation of being paid. If the bill is not paid after efforts to collect payment, which may include the hospital working to qualify

the patient for coverage under state or federal programs (which can be hindered if the patient refused to provide necessary information) or arranging a payment plan, then the hospital writes off the remaining cost of the care to “bad debt”. These monies are reported separately from charity care; however, they do have a substantial impact on a hospital’s financial well-being. In 2022, hospitals wrote off over **$203 million in bad debt** (a 6% increase over 2021). As with charity care, this is based on the actual cost to provide care.

Quality & Patient Safety

Idaho's hospitals prioritize quality and patient safety, focusing on clinical quality, patient perception, and patient safety to ensure patients receive the right care at the right time. Quality in a hospital can be broken down into three areas:



Clinical Quality applies to the actual medical care that a patient receives. Core measures, founded on evidence-based medicine, are one way to quantify this type of quality. Core measures assess the process of the care a patient receives based on a disease-specific category. For example, did a patient presenting at the emergency department with heart attack-like pain receive an aspirin upon arrival? Clinical quality also considers outcome measures such as length of stay, infection, and/or mortality.

Patient Safety is the work that keeps patients safe from harm. Hospitals must monitor and track events such as medication errors, infections, and injuries in order to continually make environments safe for patients and families. Staff are also surveyed as to their perception of patient safety in order to find gaps and improve overall patient safety.

Finally, there is **Patient Perception**. Patient perception plays a crucial role in hospital quality by measuring how patients perceive their care during their hospital stay. This is assessed through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which includes 27 questions about the hospital experience, such as communication with doctors and nurses, staff responsiveness, hospital cleanliness, pain management, and discharge planning. The feedback from this survey helps hospitals identify areas for improvement and enhance overall patient satisfaction.

Patient and Family Engagement, is the value created through patient and family interaction. Engaging patients and their families in care decisions and education is crucial for improving health outcomes and patient satisfaction.

By changing our healthcare system to focus on providing the right care at the right time in the right setting rather than fragmented, episodic treatment, not only do patients benefit but we begin to weed out some of the barriers to health and wellness by making high-quality, efficient care the standard for Idaho's healthcare delivery system. By having all parts of the system work together – including primary care providers, insurers, and hospitals as well as specialists, government payers and affiliated caregivers – Idahoans will be able to attain better health through better healthcare outcomes.

Collectively, Idaho's hospitals have and are engaged in numerous quality and patient safety initiatives through multiple entities to capture and utilize data that drive change and improve patient care. A handful of these initiatives include:

HQIC Focus:

- Behavioral Health
- Opioid Misuse
- Patient Safety
- Care Transitions
- Pandemic

Hospital Quality Improvement Contractor (HQIC) –is a national CMS patient safety initiative to align, accelerate, and amplify ambitious goals of reducing all causes of inpatient harm. In Idaho, from 2013-2024, 23 rural and critical access hospitals participated in this IHA-coordinated program. CMS is set to continue this program with a new (13th) scope of work in 2025.

FLEX Medicare Beneficiary Quality Improvement Project (MBQIP) – is a federally-funded initiative working to ensure CAH's are prepared to meet future quality requirements and demonstrating value through providing cost-efficient quality care.

Quality Improvement Organization (QIO) - The QIO Program, one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries, is an integral part of the Department of Health and Human Services' National Quality Strategy for providing better care and better health at lower cost. Idaho's QIO is Comagine Health.

Improving the health of Idahoans – while addressing issues of quality, healthcare access and cost – relies heavily on incorporating proven practices, engaging patients in their healthcare, and partnering with other providers and payers to assure the best possible outcomes.

Hospital Accreditation

Idaho's hospitals maintain quality and safety through accreditation from the Centers for Medicare and Medicaid Services (CMS). All hospitals must adhere to CMS Conditions of Participation (CoP) and Conditions for Coverage (CfC) in order to participate in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoP / CfC.

In addition to the federal accreditation, hospitals may also voluntarily apply to be certified by outside organizations. The most common accrediting agencies used by Idaho hospitals are the Joint Commission and DNV/NIAHO.

Joint Commission is an independent, not-for-profit organization that accredits and certifies over 20,000 US healthcare organizations and programs. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality. In Idaho, 23 community hospitals currently have Joint Commission accreditation.

DNV/NIAHO accreditation is a multi-year process that focuses on quality and patient safety through a more efficient and outcomes-based accreditation program. The program integrates CMS Conditions of Participation (COPs) with the ISO 9001 Quality Management Program. Currently, 15 hospitals have DNV/NIAHO accreditation.

Credentialing and Privileging

Credentialing is the basis for appointing healthcare professionals to the medical staff of a hospital or other healthcare organization. Medical staff may or may not be directly employed by the hospital. The process of credentialing is used by hospitals to ensure the qualifications of a licensed physician or other healthcare provider. Credentialing requires an evaluation of the provider's education, training, experience, competence and judgment, as well as his or her scope of practice.

Additionally, credentialing requires a review through a primary source verification (e.g. the Office of the Inspector General (OIG) exclusion list, National Provider Data Bank

Report, criminal history report, current license and DEA certificate, state licenses, sanctions or disciplinary action, and specialty board status). Once a credentialed staff member is granted clinical privileges by the Board of Trustees, they are permitted to perform certain clinical duties within the organization as defined by the institution's medical staff.

Credentialing is also performed by health plans before facilities and providers are accepted into a plan's provider network. Many hospitals and health systems that have a large number of employed providers and their Physician Hospital Organizations (PHOs) prefer to have "Delegated Credentialing" contracts with the plans in which they participate in order to simplify the process of adding providers to a plan's network. Delegated credentialing usually requires that the hospital, health system or PHO contractually agree to perform the components described above for hospital credentialing as well as other activities required by the National Committee for Quality Assurance (NCQA) and the plan.

Hospital Workforce

Idaho's hospitals are home to hundreds of different careers and continue to lead local and statewide economic growth through well-compensated jobs. From medical practitioners and nurses to technology, training, data analytics, finance, and patient and family relations, there are opportunities for Idahoans to obtain careers that can support them while offering opportunities for advancement and long-term career development.

Idaho's Department of Labor expects the demand for healthcare employees will continue growing. Current Department of Labor research shows a demand for 12,000 new healthcare practitioners and support personnel by 2026. With Idaho's growth leading the nation, and with an aging population, that demand will be even higher. While this provides substantial career opportunities for Idahoans, hospitals (and the healthcare field) also continue to experience intense shortages. Many of these shortages are not unique to Idaho and leave hospitals competing regionally and nationally for qualified employees.

Forecasts by state and national economists indicate these shortages will continue to plague Idaho and the rest of the country. Growing and filling the education pipeline must be a high priority to ensure Idahoans have access to quality healthcare close to home. Knowing the importance of workforce development, Idaho's hospitals invest millions into medical technical education, nursing education and medical residency programs.

In most communities, the hospital is one of the larger employers. This is even more common in smaller and rural communities where hospitals fill a majority of the local healthcare needs. Hospitals may operate clinics, hire primary care physicians, or bring in specialists from larger communities to make healthcare readily and locally available.

Physicians

In Idaho, physician employment by hospitals – including primary care, specialists, hospitalists and others – has become an important aspect in providing local healthcare for several reasons:

Improves access to care – Imagine being diagnosed with cancer or another ailment with the need for repeated and intense treatment. In many Idaho communities, this could mean an hours-long drive to a larger urban hospital. Instead, Idaho hospitals work to bring practitioners to the community where they are equipped to provide the care needed.

Improves alignment with quality initiatives and patient safety – As part of the hospital staff, physicians lead the work defining quality metrics, best practices, and the best paths to reaching high quality and safe hospital care.

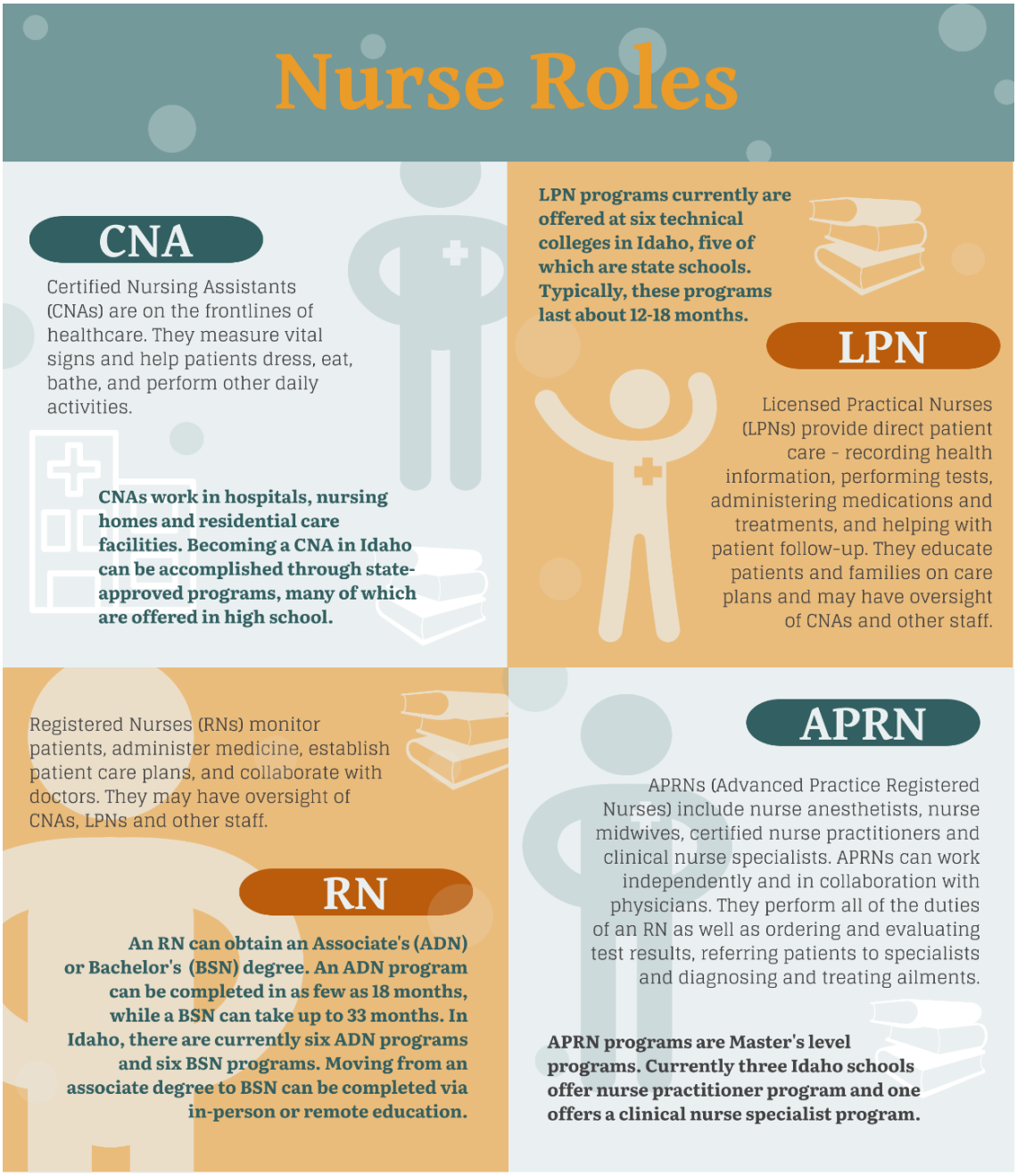
Improves quality of life – For many, being able to access care in their local community keeps patients close to their support structure. By having physicians as part of the staff, hospitals are able to offer a wider range of services locally.

The hospital-employed model isn't the only way a doctor can work with local hospitals nor is it the only solution for doctors. Many doctors elect to be part of small practices, groups within a specific medical scope, own their own businesses, or embrace other arrangements. For some, being part of the hospital staff fulfills their individual situation. For newly graduated doctors, there can be incentives to help pay the significant debt following medical school. For others, their preferences may be in working more closely with patients and worrying less about the operational aspects of running a practice.

Idaho needs to continue to be open to options that welcome and retain doctors. This is particularly important when it comes to primary care which includes general practice, family practice, obstetrics and gynecology, pediatric, geriatric and internal medicine doctors. For primary care physicians per capita, Idaho ranks last in the country. Currently, Idaho has about 95 primary care doctors per 100,000 Idahoans (the lowest per capita rate in the nation). To exacerbate the situation, the need for these jobs is expected to increase nearly 10% over the next ten years. The projection takes into account both new people moving into Idaho and an aging physician workforce.

With the growing physician shortage, physician assistants and nurse practitioners have become instrumental in providing primary and preventive care. Physician assistants diagnose illness, develop and managed treatment plans, prescribe medications and can serve as the patient's principal provider. The demand for these practitioners is anticipated to grow nearly 33% by 2026.

Nurses



Nurses are a critical part of Idaho's healthcare network. Nurses can assume many different responsibilities and serve in numerous places including hospitals, physician offices, independent practices, home health services, and long-term care facilities.

Idaho's hospitals continue to face issues that arise from a nationwide nursing shortage. As has been the case for years, a registered nurse continues to be among the hardest

positions for Idaho hospitals and other providers to fill. At any recent point in time, there are over 1,400 openings in Idaho for registered nurses. But that is not the only nursing shortage area:

Licensed Practical Nurses are experiencing an evolving scope of practice. LPNs ranked as the 24th hardest job to fill in a statewide analysis. As the healthcare system adapts to address more patient needs outside the hospital, there is an increased need for LPNs to assist with care integration and other duties. The need for LPNs is expected to grow 13.5% between 2016 and 2026.

The need for CNAs (certified nursing assistants) is expected to grow 21.7% by 2026 in Idaho. These individuals provide hands on care to patients under the direction of LPNs or registered nurses.

Advanced Practice Nurses have advanced training in diagnosing and treating illness. The need for nurse practitioners is expected to grow 35% by 2026.

The COVID pandemic exacerbated the nursing shortage, which saw many in the nursing profession choose to retire early or leave their careers altogether. That fueled a workforce shortage, but also a loss of institutional and technical knowledge that will take time to replace. When those nursing positions were backfilled by traveling nurses, the greatly inflated expense rapidly ate away at hospital personnel budgets, and the number of staffed beds that could remain open. The following is the latest Idaho Department of Labor information on statewide healthcare workforce shortages.

Hot Healthcare Jobs in Idaho - November 2024

Occupation	Open Postings	Annual Growth Rate	Hourly Wage
Registered Nurses	1306	4%	38.53
Nurse Practitioner	234	3%	58.97
Physician Assistants	38	7%	58.99
Pharmacists	145	2%	64.22
Physical Therapists	114	3%	44.76
Respiratory Therapists	42	4%	33.37
Health Care Social Workers	33	-6%	32.43
Diagnostic Medical Sonographers	23	11%	43.57
Radiologic Technologists	65	5%	34.20

Hospital Leadership

Idaho's hospital CEOs are responsible for ensuring the mission of a hospital is achieved. Activities that support the delivery of quality care to patients include day-to-day operations as well as long-term strategic planning. CEOs must also cultivate and maintain good relationships with physicians, primary care clinics, rehabilitation facilities, other hospitals, nursing homes, home health agencies and other healthcare providers that provide the continuum of care needed by patients in the community. In addition, they must manage a large, complex and specialized workforce that constitutes one of the community's largest employers.

CEOs are accountable, not only for the quality of care provided to the patients, but also to the community by working to assure the financial well-being of the hospital so it can continue to support the healthcare and economic needs of the community. CEOs are also responsible for ensuring their hospitals are compliant with the requirements of accreditation organizations, federal, state, and other regulatory entities (see Resources).

Recruiting and retaining qualified executives is a challenging task for hospital trustees. Nationally, hospital CEO turnover saw a significant increase in 2023. In 2022, CEO turnover was 16%, the lowest rate since 2011. However, according to Challenger, Gray and Christmas Inc, an international outplacement firm, in 2023 the CEO turnover rate increased to 23.7% or a 42% increase over 2022.

For Idaho, and especially for our more rural communities, it can be more difficult than elsewhere in the nation to recruit quality executives. Recruiting and retaining quality executive leadership is one of the most important jobs trustees have and is critical to ensuring local healthcare needs are met.

Healthcare Education

One of the most prominent ways the Idaho Hospital Association and our members address the workforce shortages impacting patients and communities is through broad-based support of education. By creating and filling the pipeline for a number of careers, we can help educate Idaho students and provide them with degrees, certifications or advanced training for in-demand positions. A few ways we support and advocate for healthcare education include:

A long history of support for
WWAMI
(The multi-state medical school partnership between University of Washington, Wyoming, Alaska, Montana, and Idaho) including financial support of students and establishing residencies.

Supporting medical school seats at
University of Utah.

Supporting the
Idaho College of Osteopathic Medicine.

Developing and maintaining
Nursing Internships, Apprenticeships, and Education
for degree advancement. Over 90% of those completing an apprenticeship program stay with the organization that supported the education.

Advancing the efforts of the
Workforce Development Council

Advocating for opportunities with
Community Colleges & High Schools
to provide students with certifications or degrees in crucial shortage positions which don't necessitate four-year degrees.

IHA and our members strongly advocate supporting existing, successful education programs as well as being open to new opportunities. We continue to support policies that align Idaho's workforce and education to build the highly skilled workforce we need while creating opportunities for continuous learning.

As Idaho pursues continued economic growth by supporting STEM education and industries, it is important to recognize healthcare's role. Our hospitals stand ready to welcome individuals with strong science and technology backgrounds into our workforce. For other STEM-based businesses looking to locate in Idaho, a key factor in their decision making will be the accessibility and quality of the healthcare their employees will need. By creating and filling the workforce pipeline and reducing healthcare shortages, we help build a stronger Idaho that is ready for growth and provides Idahoans with quality jobs.

Idaho has seen unprecedented growth in recent years – some of the highest in the nation. People and businesses from around the country are choosing to come to Idaho because of our opportunities, supportive business climate, robust economy, and our unmatched natural beauty. In response, Idaho has made record investments in infrastructure to support this growth – roads, bridges, schools, utilities – all things necessary for maintaining our unique quality of life.

Healthcare is a critical part of those infrastructure needs. A healthy workforce is necessary for thriving businesses, communities, and families. Industries looking to relocate to Idaho consider the access to and quality of healthcare and hospitals to support their employees. As safe roads and bridges are needed to get our citizens to their jobs and back home, high-quality and accessible healthcare is critical to keeping them healthy once they are there. A healthy, thriving workforce is essential to support all the reasons people and states across this nation are looking to Idaho as a positive example. Investments in healthcare – large and small - come back to our communities many times over. ***You can't have a healthy economy without Health.***

IHA Members

Member Name	Address	City	Zip	Phone
Bear Lake Memorial Hospital	164 South Fifth St.	Montpelier	83254	(208) 847-1630
Benewah Community Hospital	229 South Seventh St.	St. Maries	83861	(208) 245-5551
Bingham Memorial Hospital	98 Poplar St.	Blackfoot	83221	(208) 785-4100
Bonner General Health	520 North Third Ave.	Sandpoint	83864	(208) 263-1441
Boundary Community Hospital	6640 Kaniksu St.	Bonners Ferry	83805	(208) 267-3141
Caribou Medical Center	300 S. Third W. St.	Soda Springs	83276	(208) 547-3341
Cascade Medical Center	402 Lake Cascade Pkwy.	Cascade	83611	(208) 382-4242
Cassia Regional Hospital	1501 Hiland Ave.	Burley	83318	(208) 678-4444
Clearwater Valley Health	301 Cedar St.	Orofino	83544	(208) 476-4555
Cottonwood Creek Behavioral Hospital	2131 S Bonito Way	Meridian	83642	(208) 202-4700
Eastern Idaho Regional Medical Center	3100 Channing Way	Idaho Falls	83404	(208) 529-6111
Franklin County Medical Center	44 North 1st East	Preston	83263	(208) 852-0137
Gritman Medical Center	700 South Main St.	Moscow	83843	(208) 882-4511
Idaho Falls Community Hospital	2327 Coronado St.	Idaho Falls	83404	(208) 528-1000
Idaho State Hospital North	300 Hospital Dr.	Orofino	83544	(208) 476-4511
Idaho State Hospital South	700 East Alice St.	Blackfoot	83221	(208) 785-1200
Intermountain Hospital	303 North Allumbaugh St.	Boise	83704	(208) 377-8400
Kootenai Health	2003 Kootenai Health Way	Coeur d'Alene	83814	(208) 625-4000
Lifeways Hospital	8050 W. Northview St.	Boise	83704	(208) 327-0504
Lost Rivers Medical Center	551 Highland Dr.	Arco	83213	(208) 252-7654
Madisonhealth	450 East Main St.	Rexburg	83440	(208) 359-6900
Minidoka Memorial Hospital	1224 8th St.	Rupert	83350	(208) 436-0481
Nell J. Redfield Memorial Hospital	150 North 200 West	Malad City	83252	(208) 766-2231
North Canyon Medical Center	267 North Canyon Dr.	Gooding	83330	(208) 934-4433

Member Name	St.	City	Zip	Phone
Northern Idaho Advanced Care Hospital	600 North Cecil	Post Falls	83854	(208) 262-2800
Portneuf Medical Center	777 Hospital Way	Pocatello	83201	(208) 239-1000
Power County Hospital District	510 Roosevelt St.	American Falls	83211	(208) 226-3200
Rehabilitation Hospital of the Northwest	3372 East Jenalan Ave.	Post Falls	83854	(208) 262-8700
Saint Alphonsus Medical Center - Nampa	4300 E. Flamingo Ave.	Nampa	83687	(208) 205-1000
Saint Alphonsus Regional Medical Center	1055 North Curtis Road	Boise	83706	(208) 367-2121
St. Alphonsus Regional Rehabilitation Hospital	711 North Curtis Road	Boise	83706	(208) 605-3000
Shoshone Medical Center	25 Jacobs Gulch Road	Kellogg	83837	(208) 784-1221
St. Joseph Regional Medical Center	415 Sixth St.	Lewiston	83501	(208) 743-2511
St. Luke's Boise Medical Center	190 East Bannock St.	Boise	83712	(208) 381-2222
St. Luke's Elmore Medical Center	895 North 6th East	Mountain Home	83647	(208) 587-8401
St. Luke's Jerome Medical Center	709 North Lincoln St.	Jerome	83338	(208) 814-9500
St. Luke's Magic Valley Medical Center	801 Pole Line Road West	Twin Falls	83303	(208) 814-1000
St. Luke's McCall Medical Center	1000 State St.	McCall	83638	(208) 634-2221
St. Luke's Meridian Medical Center	520 S. Eagle Road	Meridian	83642	(208) 706-5000
St. Luke's Nampa Medical Center	9850 W. St. Luke's Dr.	Nampa	83687	(208) 505-2000
St. Luke's Rehabilitation Hospital	600 N. Robbins Road	Boise	83702	(208) 489-4444
St. Luke's Wood River Medical Center	100 Hospital Dr.	Ketchum	83340	(208) 727-8800
St. Mary's Health	701 Lewiston St.	Cottonwood	83522	(208) 962-3251
Steele Memorial Medical Center	203 S. Daisy St.	Salmon	83467	(208) 756-5600
Syringa Hospital & Clinics	607 West Main St.	Grangeville	83530	(208) 983-1700
Teton Valley Health	120 East Howard	Driggs	83422	(208) 354-2383
Valor Health	1202 East Locust St.	Emmett	83617	(208) 365-3561
Veterans Affairs Medical Center	500 West Fort St.	Boise	83702	(208) 422-1000
Vibra Hospital of Boise	6651 W. Franklin Road	Boise	83709	(208) 489-9500
Weiser Memorial Hospital	645 East 5th St.	Weiser	83672	(208) 549-0370
West Valley Medical Center	1717 Arlington Ave.	Caldwell	83605	(208) 459-4641

Hospital Oversight Entities

Idaho's community hospitals interact with dozens of federal, state, local and affiliated entities each day in meeting strict, varied and expansive rules, guidance and regulations.

OVERSIGHT

BFS – Bureau of Facility Standards
CMS – Centers for Medicare & Medicaid Services
DEQ – Idaho Dept. of Environmental Quality
DHW – Idaho Department of Health and Welfare
DNV - DNV Healthcare
EPA – Environmental Protection Agency
FCC – Federal Communication Commission
FTC – Federal Trade Commission
HFAP – Healthcare Facilities Accreditation Prog.
HHS – Office of Public Health & Science
NRC – Nuclear Regulatory Commission
TJC - The Joint Commission
VHA – Veterans Health Administration

PROGRAM INTEGRITY

CERT – Comprehensive Error Rate Testing
MIC – Medicaid Integrity Contractor
MIP – Medicare Integrity Program
OIG – US Office of the Inspector General
RAC – Recovery Audit Contractor
SMRC – Supplemental Medical Review Contractor
SUR – Medicaid Surveillance & Utilization Review
ZPIC – Zone Program Integrity Contractor

MEDICAL & CLINICAL

AHRQ – Agency for Healthcare Research & Quality
BOM – Idaho Board of Medicine
BON – Idaho Board of Nursing
BOP – Idaho Board of Pharmacy
CDC – Centers for Disease Control
FDA – Food & Drug Administration
HCAHPS – Hospital Consumer Assessment of Healthcare Providers and Systems
HRSA – US Health Resources & Services Admin.
IDOPL – Idaho Division of Occupational and Professional Licenses
IBOE – Idaho Board of Education
ONC – Office of the National Coordinator for Health Information Technology

FINANCIAL

County Assessors
IDOI – Idaho Department of Insurance
IRS – Internal Revenue Service
ISOS – Idaho Secretary of State
ITC – Idaho Tax Commission
MAC – Medicare Administrative Contractor
PERM – Payment Error Rate Measurement
PRRB – Provider Reimbursement Review Board
SEC – Securities & Exchange Commission

QUALITY

DNV – DNV Healthcare
HQIC – Hospital Quality Improvement Contractors
MBQIP – Medicare Beneficiary Quality Incentive Prog.
PSO – Patient Safety Organization
QIN – Quality Improvement Network
QIO – Quality Improvement Organization
TJC – The Joint Commission
TSE – Idaho Time Sensitive Emergency System

LEGAL

AG – Idaho Office of Attorney General
DEA – US Drug Enforcement Agency
DOJ – US Dept. of Justice
FBI – Federal Bureau of Investigation
ISOS – Idaho Secretary of State
MFCU – Idaho Medicaid Fraud Control Unit
OCR – Office for Civil Rights
OIG – US Office of the Inspector General

PERSONNEL

DOL – US Dept. of Labor
IDOL - Idaho Dept. of Labor
IIC - Idaho Industrial Commission
OCR – Office of Civil Rights
OFCCP – Office of Federal Contract Compliance Programs
OSHA – Occupational Safety & Health Administration
NISOH – National Institute for Occupational Safety & Health
NLRB – National Labor Relations Board

TRANSPORTATION

Bureau of EMS
DOT – US Dept. of Transportation
IDOT – Idaho Dept. of Transportation
ISP – Idaho State Police
FAA – Federal Aviation Administration
Local & County Law Enforcement

Healthcare Glossary

Accountable Care Organization (ACO) – ACOs are groups of doctors, hospitals, and other healthcare providers, who come together to give coordinated high-quality care to their patients. The goal of coordinated care is to ensure patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. An ACO shares in the savings or losses it achieves for the Medicare/Medicaid program. Payments are tied to quality metrics and the cost of care.

Accreditation – Certification by a recognized organization that an individual, a service or a facility has met a set of standardized criteria typically determined by a process set by the certifying organization.

Acute Care Hospital – A facility that provides 24/7 services designed to meet the needs of patients who require short-term care for a period of less than 30 days.

Allied Health Professional – Persons who are not nurses or physicians but have special training and are licensed when necessary. They work under the supervision of a health professional and provide direct patient care. They include, but are not limited to, respiratory, physical and occupational therapists; radiology technologists and technicians; medical laboratory technologists and technicians; and surgical technologists.

Allowable Costs – In terms of Medicare and Medicaid, these are costs deemed eligible for reimbursement in treating participants and/or organizational support. Not all organizational costs are allowable.

Ambulatory Care – Outpatient healthcare services, where no overnight stay in a healthcare facility is required.

American College of Radiology (ACR) – The recognized organization for imaging (radiology) accreditation.

American Hospital Association – The nation's principal trade association for hospitals, with offices in Washington, D.C., and Chicago. IHA partners closely with AHA but is an independent organization.

Ancillary Care Services – Diagnostic or therapeutic services, such as laboratory, radiology, pharmacy and physical therapy, performed by non-nursing departments.

Any Willing Provider – Terminology relating to Idaho statute (41-3927) which requires insurance companies to allow any physician or other provider to become members of their network, providing they are qualified and willing to meet the terms and conditions of the participating provider contract.

Bad Debt – The costs absorbed by hospitals or physicians for care provided to patients from whom payment was expected but not received. Bad debt differs from charity care.

Balanced Billing – An occurrence in which a physician bills you for the difference between the provider's charge and the allowed amount. A network's contracted providers may not balance bill for discount on covered services. Out-of-network providers, not bound by contracts or rate agreements, have the ability to bill patients for the entire remaining balance.

Capitation – A payment arrangement for healthcare providers. It pays a physician or group of physicians a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

CAT Fund – Refers to Idaho's Catastrophic Healthcare Cost Program. The state-funded program was established to pay for indigent medical costs once the county limit of $11,000 per claim is reached. H316 in 2022 eliminated the CAT fund, but kept it open to receive recuperated payments from the patient through repayment or property liens.

Charge – The dollar amount that a healthcare provider assigns to a specific unit of service. A "charge" may not reflect the actual cost involved in providing that service or the amount paid by the patient.

Charity Care – Charity care represents the healthcare services that are provided under a hospital's charitable care program and where payment is not expected because the patient has a demonstrated inability to pay for some or all of the services.

Coinsurance – The percentage of either billed charges or the insurance plan's contract rate that a member is required to pay for covered services.

College of American Pathologists (CAP) – CAP is an internationally recognized program designed to help laboratories achieve the highest standards of excellence to impact patient care positively.

Community Benefit – Programs or services that address community health needs – including those of the poor or other underserved groups – and provide measurable improvement. These are proactive, strategic investments that address social and economic determinants of health and access to care.

Conditions of Participation (CoPs) – Standards that organizations must meet to participate in Medicare and Medicaid. These conditions are the foundation for improving quality and protecting the health and safety of beneficiaries.

Copayment or Copay – A defined amount of payment per visit a member must pay for healthcare services under an insurance plan.

Cost Share – The portion of the fee for healthcare services that an insurer requires the plan member to pay, including copayments, coinsurance and deductible.

Cost Shifting – A phenomenon in the healthcare system in which providers are inadequately reimbursed for their costs by some payers and subsequently raise their prices for other payers in an effort to recoup costs.

Covered Services – Those healthcare services for which a member is entitled to benefits under the terms of their insurance policy.

Credentialing – Generally used as the basis for appointing healthcare professionals to a hospital's staff, it is the process used to analyze the qualifications of a licensed practitioner's education, training, experience, competence and judgment. A credentialed staff member is permitted to perform clinical duties at the hospital.

Critical Access Hospital (CAH) – Established under the Balanced Budget Act of 1997, CAHs are hospitals located in rural areas with no more than 25 acute-care beds. They receive cost-based payment for Medicare patients and are relieved from some Medicare regulations.

Deductible – The amount that a member must pay for covered services during a specified period (usually a policy year) before benefits will be paid by the insurer.

Delegated Credentialing – A formal process by which an organization gives another entity the authority to perform credentialing functions on its behalf.

Diagnosis Related Group (DRG) – A classification that standardizes hospital payments and encourages cost containment

initiatives. In general, a DRG payment covers charges associated with an inpatient stay from the time of admission to discharge.

Disproportionate Share Hospital (DSH) – A hospital with a disproportionately large share of low-income or uninsured patients. Both Medicaid and Medicare augment payment to these hospitals to offset this added burden.

DNV Healthcare (DNV) – DNV is a voluntary accreditation agency that surveys enrolled hospitals regarding many aspects of quality.

Electronic Health Record (EHR) – A digital version of a patient's medical charts. EHRs are real-time records that make information available instantly and securely to authorized users. EHRs can contain a patient's medical history, diagnoses, medications, allergies, images, test results and much more. EHRs are designed to be inclusive of all clinicians involved in the patient's care.

EMTALA – Emergency Medical Treatment and Active Labor Act, a federal law passed in 1986, ensures hospitals provide care to anyone needing emergency treatment, regardless of citizenship, legal status, or ability to pay.

ERISA – Employee Retirement Income Security Act of 1974, a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry.

EOB, Explanation of Benefits, EOMB, Explanation of Medical Benefits or Remittance Advice – A document that summarizes how reimbursement was determined in the payment of a health plan claim.

Fee for Service – In a fee-for-service arrangement, providers are paid based on the amount of healthcare services they deliver. This is a system based on the volume of work versus the value which is measured with outcomes and cost.

Health Information Technology for Economic and Clinical Health Act (HITECH) – Part of the American Recovery and Reinvestment Act of 2009 (ARRA), the HITECH Act contains incentives related to healthcare information technology (e.g. creation of a national healthcare infrastructure) and contains specific incentives designed to accelerate the adoption of electronic health record (EHR) systems among providers.

Health Insurance Portability and Accountability Act (HIPAA) – Title I requires employers and health plans to allow a new employee's medical insurance coverage to remain continuous without regard to pre-existing conditions. Title II requires the establishment of national standards for electronic healthcare transactions, and national identifiers for providers, health insurance plans and employers. HIPAA also addresses security and privacy of health data.

Healthcare Acquired Condition – A condition that develops while a patient is in a healthcare facility, such as an infection, a pressure ulcer or some type of injury.

Idaho Patient Care Act – Passed in 2020, the IPA created a number of mandates for hospitals and healthcare providers regarding the patient billing process and medical debt collections. It also set caps on attorney fees for extraordinary medical debt collections.

Intergovernmental Transfer (IGT) – Local governmental funds transferred to the state on behalf of a public provider to provide the state matching funds for supplemental payments made to that public provider.

The Joint Commission (TJC) – A voluntary accreditation agency that surveys enrolled hospitals regarding many aspects of quality.

Licensed Beds – The maximum number of beds authorized by a government agency for a healthcare organization to admit patients.

Long-Term Acute Care Hospital (LTAC) – A hospital providing specialized care to medically complex patients who usually require an extended hospital stay.

Long-Term Care Facility (LTCF) – Any residential healthcare facility that administers health, rehabilitative or personal services for a prolonged period of time.

Managed Care – A mechanism for financing and/or delivering healthcare intended to control cost, utilization, and quality of care. The state pays the management entity up to a 15% fee for administering the program.

Medicaid Expansion – Unlike traditional Medicaid, Medicaid Expansion provides coverage to individuals with incomes less than 138% of the federal poverty level. Congress, by statute, has locked the federal/state match rate at 90% federal, and 10% state. Without Medicaid Expansion, there is no safety-net program to compensate for the care provided to low-income, uninsured Idahoans.

Medicaid Integrity Contractor (MIC) – An auditor hired by the Centers for Medicare and Medicaid Services (CMS) to review Medicaid claims for mis-payment.

Medical Home – A model of primary and preventive care delivery in which the patient has a continuous relationship with a personal physician in a physician-directed medical practice that is whole person oriented and where care is integrated and coordinated.

Member or Covered Person – Someone with insurance coverage through a health plan. May also be referred to as an Enrollee or Beneficiary.

National Committee for Quality Assurance (NCQA) – A non-profit organization that sets quality standards, evaluates and accredits managed care plans and other healthcare organizations.

Out-of-Network Care – Healthcare services provided to a health plan member by a provider who does not participate in that plan's contracted provider network.

Outpatient Prospective Payment System (OPPS) – A determined payment methodology for a Medicare outpatient procedure.

Payer – An organization (such as the federal government for Medicare or a commercial insurance company) or person who directly reimburses healthcare providers for their services.

Present on Admission (POA) – Whether or not a patient has a certain condition at the time of being admitted to a hospital. These conditions include different types of infections and pressure ulcers.

Prior Authorization – A process by which a healthcare plan determines that care is medically necessary, and costs will be covered by the plan.

Prospective Payment System (PPS) – A system in which payment for services is determined before the services are actually provided and that amount is reimbursed to the provider regardless of the actual cost of services.

Provider Network or Network – A group of providers who have contracted with a managed care plan under which they agree to accept reduced rates and abide by other plan rules in exchange for either increased volume of patients or the ability to receive payment for care provided to insurance plan members.

Quality Measure – A tool that helps measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality healthcare and/or that relate to one or more quality goals for healthcare.

Recovery Audit Contractor (RAC) – An auditor hired by the Centers for Medicare and Medicaid Services (CMS) to review Medicare claims for mis-payment.

Rural Emergency Hospital (REH) - A new hospital designation designed to maintain access to care in rural communities. An REH provides emergency services and observation care but is prohibited from providing inpatient services or exceeding an annual average patient length of stay of 24 hours.

Serious Adverse Event – An unexpected event that happens during a hospital admission that results in harm or injury to a patient.

Specialty Hospital – A limited-service hospital designed to provide medical specialty care such as surgical or orthopedic care.

Swing Beds – Acute care hospital beds that can also be used for long-term care, depending on the needs of the patient and the community. Only those hospitals with fewer than 100 beds and located in a rural community, where long-term care may be inaccessible, are eligible to have swing beds.

Surprise Billing – When a patient unexpectedly receives care from an out-of-network provider. This can happen in a number of instances, such as when a patient is treated by their in-network physician, but the lab sample is sent to an out-of-network laboratory or when a patient is treated at the emergency department of an in-network hospital, but the on-call physician specialist called in to provide care is not in the patient's insurance network.

Tobacco Master Settlement Agreement – In 1998, Idaho was one of 46 states to participate in a Master Settlement Agreement (MSA) with the four largest tobacco companies in the U.S. The MSA was a result of multiple state lawsuits against the tobacco companies that sought recovery for Medicaid and other public health expenses incurred in the treatment of smoking-induced illnesses. Idaho created the Millennium Fund for those MSA payments and uses the interest to fund various health-related programs.

Trauma System – An organized approach to facilitating and coordinating a multidisciplinary system response to severely injured patients.

Uncompensated Care – Care given for which payment is not received, or for which only a portion of the cost is reimbursed. Includes charity care, Medicaid underpayments, legislated care underpayments, and bad debt.

Upper Payment Limit – The Upper Payment Limit is a federal supplemental payment program that allows hospitals to make up some of the losses they take on Medicaid reimbursement from the states. The UPL is the difference between what Medicaid pays and what Medicare would have paid for the same service. If hospitals provide the required state match, they can access the federal supplement to the Medicare "upper limit payment limit."

Utilization Review – The process by which a managed care company controls the provision of healthcare services through determination of medical necessity of care, including pre-certification, prior authorization, concurrent review and retrospective review.

Value Based Care / Pay for Performance – Value-based care is a delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes. Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce incidence and effects of chronic disease, and live healthier lives in an evidence-based way. This model also penalizes providers for poor outcomes, medical errors, or increased costs. Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of healthcare services they deliver. The "value" in value-based healthcare is derived from measuring health outcomes against the cost of delivering the outcome.

Value Care Organizations (VCO) - In 2020, H315 began the transition of Medicaid from a fee-for-service reimbursement structure to a value-based arrangement. VCOs - which include hospital networks and primary care providers - are held accountable for outcomes and costs, in exchange for an ability to share in savings.