

Dear Senators MARTIN, Souza, Jordan, and
Representatives WOOD, Wagoner, Chew:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of
the Department of Health and Welfare:

IDAPA 16.03.01 - Eligibility for Health Care Assistance for Families and Children - Temporary and
Proposed Rule (Docket No. 16-0301-1901);

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-1704);

IDAPA 16.03.18 - Medicaid Cost-Sharing - Proposed Rule (Docket No. 16-0318-1901).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the
cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research
and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative
Services. The final date to call a meeting on the enclosed rules is no later than 11/21/2019. If a meeting is
called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis
from Legislative Services. The final date to hold a meeting on the enclosed rules is 12/20/2019.

The germane joint subcommittee may request a statement of economic impact with respect to a
proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement,
and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has
been held.

To notify Research and Legislation, call 334-4854, or send a written request to the address on the
memorandum attached below.



Eric Milstead
Director

Legislative Services Office

Idaho State Legislature

Serving Idaho's Citizen Legislature

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Health & Welfare Committee and the House Health & Welfare Committee

FROM: Principal Legislative Drafting Attorney - Elizabeth Bowen

DATE: November 01, 2019

SUBJECT: Department of Health and Welfare

IDAPA 16.03.01 - Eligibility for Health Care Assistance for Families and Children - Temporary and Proposed Rule (Docket No. 16-0301-1901)

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-1704)

IDAPA 16.03.18 - Medicaid Cost-Sharing - Proposed Rule (Docket No. 16-0318-1901)

Summary and Stated Reasons for the Rule

Docket No. 16-0301-1901: This temporary and proposed rule provides that inmates may receive Medicaid services if they need inpatient care at a hospital. It also incorporates the Medicaid expansion population into the rules. The Governor finds that the temporary rule is justified to comply with Proposition 2 and S.B. 1204 (2019).

Docket No. 16-0310-1704: This proposed rule revises the methodology for setting reimbursement rates at developmental disability agencies, residential habilitation agencies, supported employment agencies, and targeted service coordinators.

Docket No. 16-0318-1901: This proposed rule clarifies that Native American and Alaskan Native Medicaid participants with disabilities are exempt from participation in home and community-based waiver services. The purpose of the rule change is to conform with federal regulations. Additionally, the rule reduces eligibility categories for the personal needs allowance from six to two by eliminating marital status as a factor for consideration.

Negotiated Rulemaking / Fiscal Impact

Docket No. 16-0301-1901: Negotiated rulemaking was not conducted due to the nature of the rule change, which is to conform the rule to state law. There is no anticipated negative fiscal impact on the state general fund.

Docket No. 16-0310-1704: Negotiated rulemaking was conducted, and there is no anticipated negative fiscal impact on the state general fund.

Docket No. 16-0318-1901: Negotiated rulemaking was conducted, and there is no anticipated negative fiscal impact on the state general fund.

Statutory Authority

This rulemaking appears to be within the Department's statutory authority.

cc: Department of Health and Welfare
Frank Powell and Trinetta Middlebrook

***** PLEASE NOTE *****

Per the Idaho Constitution, all administrative rules may be reviewed by the Legislature during the next legislative session. The Legislature has 3 options with this rulemaking docket: **1)** Approve the docket in its entirety; **2)** Reject the docket in its entirety; or **3)** Reject the docket in part.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.01 – ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-1901

NOTICE OF RULEMAKING – TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2020.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, 56-203, 56-209, 56-239, 56-250, 56-253, 56-255, 56-256 and 56-257, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2019.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking contains the specific changes described below:

*Section 281 provides Medicaid services to inmates of a public institution should they need inpatient care in a hospital. This section will align with the rule in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," around the ineligibility of inmates of public institutions;

*Section 400 outlines the rules that govern the newly expanded adult population that may receive Medicaid for people 19 - 64 years of age. This section also includes the pregnancy Medicaid program since the income limits and coverage aligns with other adult coverage; and

*Section 500 removes the relevant rules related to Pregnant Women coverage incorporated into section 400.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1) section b, Idaho Code, the Governor has found that temporary adoption of the rule is appropriate to comply with deadlines in amendments to governing law or federal programs. These rules are a result of statute changes due to the passage of Proposition 2 and S1204 (2019) which take effect 1/1/2020.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year:

These rule changes have no anticipated fiscal impact to the state general fund, will conform language, and will remove conflicting guidelines in IDAPA with state statutes that have already been adopted. These administrative rule changes do not introduce any additional costs.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is to align IDAPA code with statute.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Camille Schiller, (208) 334-5969.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2019.

Dated this 19th day of August, 2019.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5564
Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

**THE FOLLOWING IS THE TEMPORARY RULE AND THE PROPOSED TEXT
OF DOCKET NO. 16-0301-1901
(Only Those Sections With Amendments Are Shown.)**

281. MEDICAL EXCEPTION FOR INMATES.

An inmate of an ineligible public institution can receive Medicaid while they are an inpatient in a medical institution provided the inmate meets all Medicaid eligibility requirements. Medicaid begins the day the inmate is admitted and ends the day of discharge from the medical institution. (1-1-20)T

1. Inpatient. An inmate is an inpatient when they are admitted to a hospital, nursing facility, ICF/IID, or, if under the age of twenty-one (21), is admitted to a psychiatric facility. (1-1-20)T

2. Not an Inpatient. An inmate is not an inpatient when receiving care on the premises of a correctional institution. (1-1-20)T

~~281~~ -- 289. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

~~400. PARENTS AND CARETAKER RELATIVES ELIGIBLE FOR~~ MEDICAID ~~COVERAGE~~ **FOR ADULTS.**

~~In order for an individual in a household budget unit to be eligible for Medicaid coverage, the individual must meet the requirements in Subsections 400.01 through 400.06 of this rule.~~ Medicaid is available for the following adults: (4-11-15)(1-1-20)T

01. Parent, Caretaker Relative, or a Pregnant Woman. (1-1-20)T

a. The individual ~~must be~~ who is a parent, caretaker relative, or a pregnant woman in the household budget unit. (4-11-15)(1-1-20)T

~~**02b. Responsible for Eligible Dependent Child.**~~ The individual ~~must be~~ who is responsible for an eligible dependent child, which includes the unborn child of a pregnant woman. (4-11-15)(1-1-20)T

~~**03c. Live in Same Household.**~~ The individual ~~must~~ who lives in the same household with the eligible

dependent child.

~~(4-11-15)~~(1-1-20)T

02. Adults Under Age 65. The individual must: (1-1-20)T

a. Be age nineteen (19) or older and under age sixty-five (65); (1-1-20)T

b. Not entitled to or enrolled in Medicare Part A or Part B; and. (1-1-20)T

c. Not otherwise eligible for any other coverage under the State Plan. (1-1-20)T

043. MAGI Income Eligibility. For any of the eligibility groups described in Subsections 400.01 and 02, the individual must meet all income requirements of the Medicaid program for eligibility determined according to MAGI methodologies identified in Sections 300 through 303, and 411 of these rules. Eligibility is based on:

~~(4-11-15)~~(1-1-20)T

a. The number of members included in the household budget unit; ~~and~~ ~~(3-20-14)~~(1-1-20)T

b. All countable income for the household budget unit; ~~and~~ ~~(3-20-14)~~(1-1-20)T

c. Eligible individuals will have income calculated using their modified adjusted gross income (MAGI). Individuals with MAGI not greater than one hundred thirty-three per cent (133%) after applying a five per cent (5%) disregard to income are eligible to receive Medicaid in this section. (1-1-20)T

054. Member of More Than One Budget Unit. No person may receive benefits in more than one (1) budget unit during the same month. (3-20-14)

065. More Than One Medicaid Budget Unit in Home. If there is more than one (1) Medicaid budget unit in a home, each budget unit is considered a separate unit. (3-20-14)

(BREAK IN CONTINUITY OF SECTIONS)

419. TRANSITIONAL MEDICAID FOR ~~ADULTS~~ PARENTS AND CARETAKER RELATIVES.

Participants who no longer qualify for Medicaid due to an increase in earned income or working hours are eligible for an additional twelve (12) months of Medicaid. Participants must have been eligible for Medicaid during at least three (3) of the six (6) months immediately preceding the month in which the participant became ineligible.

~~(3-25-16)~~(1-1-20)T

(BREAK IN CONTINUITY OF SECTIONS)

421. PREGNANT WOMAN INELIGIBLE BECAUSE OF EXCESS INCOME.

A pregnant woman who receives health care assistance and becomes ineligible because of an increase in income will continue to receive coverage through the end of the month in which the sixtieth day of her postpartum period falls.

(1-1-20)T

~~421.2.~~ -- ~~49~~519. (RESERVED)

*Pregnancy-Related Health Coverage
(Sections 500 – 519)*

500. PREGNANT WOMAN COVERAGE.

A pregnant woman of any age is eligible for the Pregnant Woman coverage if she meets all of the non-financial and financial criteria of the coverage group. Health care assistance for Pregnant Woman coverage is limited to pregnancy-related and postpartum services. The Pregnant Woman medical assistance coverage extends through the

~~sixty (60) day postpartum period if she was eligible to receive medical assistance when the child was born. (3-28-18)~~

~~01. **Income Limit.** The individual's calculated income must not exceed one hundred thirty-three percent (133%) of the Federal Poverty Guidelines (FPG) for her family size in the application month. (3-20-14)~~

~~02. **Household Size.** The household budget unit consists of the pregnant woman, the unborn child or children if expecting more than one (1) child, and any individual determined to be part of the household budget unit based on MAGI methodologies as identified in Sections 300 through 303, and 411 of these rules. (3-20-14)~~

~~03. **Income Disregards.** A standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) for family size is applied to the MAGI income of the pregnant woman if the disregard is necessary to establish income eligibility. (3-20-14)~~

~~04. **Continuing Eligibility.** The pregnant woman remains eligible during the pregnancy regardless of changes in income. The woman must report the end of pregnancy to the Department within ten (10) days. (3-20-14)~~

~~501. **PREGNANT WOMAN INELIGIBLE BECAUSE OF EXCESS INCOME.**~~

~~A pregnant woman who receives health care assistance and becomes ineligible because of an increase in income will continue to receive coverage through the end of the month in which the sixtieth day of her postpartum period falls. (3-20-14)~~

~~502. **PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN.**~~

~~Presumptively eligible (PE) pregnant woman coverage is designed to provide some prenatal care during the time between the pregnancy diagnosis and the eligibility determination. (3-20-14)~~

~~01. **Pregnancy Diagnosis and Eligibility Determination.** A pregnant woman can get limited ambulatory prenatal care as a presumptively eligible (PE) pregnant woman through the end of the month after the month the provider completes the PE determination. (3-20-14)~~

~~02. **Qualified Provider Completes Eligibility Determination.** A qualified PE provider accepts written requests for these services and completes the eligibility determination. (3-20-14)~~

~~03. **Formal Application.** The qualified PE provider must inform the participant how to complete the formal application process. (3-20-14)~~

~~04. **Notification of Eligibility Determination Results.** Qualified PE providers are required to send the result of the PE decision and the completed application for the Pregnant Woman coverage to the Department within two (2) working days of the PE determination. (3-20-14)~~

~~05. **Presumptive Eligibility Decisions.** Notice and hearing rights of the Title XIX Medicaid program do not apply to the PE decisions. An individual is eligible for only one (1) period of PE coverage during each pregnancy. (3-20-14)~~

~~503.—519: (RESERVED)~~

(BREAK IN CONTINUITY OF SECTIONS)

545. PRESUMPTIVE ELIGIBILITY FOR CHILDREN AND ~~PARENTS~~ ADULTS.

Presumptive eligibility determination for qualifying medical coverage groups can only be provided by a qualified hospital defined in Section 011 or these rules. ~~(3-20-14)~~ (1-1-20)T

01. **Presumptive Eligibility Decisions.** Decisions of presumptive eligibility can only be made for children up to age nineteen (19), parents or caretaker relatives with an eligible child in their household, or pregnant women individuals, who meet program requirements for MAGI-based Medicaid coverage for families and children. ~~(4-11-15)~~ (1-1-20)T

02. Presumptive Eligibility Determination. Presumptive eligibility determinations are made by a qualified hospital when an individual receiving medical services is not covered by health care insurance and the financial assessment by hospital staff indicates the individual is eligible for Medicaid Coverage in Idaho. This determination is made by hospital staff through an online presumptive application process: (3-20-14)

a. Prior to completion of a full Medicaid application; and (3-20-14)

b. Prior to a determination being made by the Department on the full application. (3-20-14)

03. Presumptive Eligibility Period. The presumptive eligibility period begins on the date the presumptive application is filed online and ends with the earlier of the following: (3-20-14)

a. The date the full eligibility determination is completed by the Department; or (3-20-14)

b. The end of the month after the month the qualified hospital completed the presumptive eligibility determination. (4-11-15)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1704

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-118, 56-202(b), and 56-264, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

PUBLIC (LIVE) HEARING	
Wednesday, October 16, 2019 - 10:00 a.m. (MDT)	
Medicaid Central Office 3232 Elder Street Conference Room D West/East Boise, ID 83705	
Via VIDEO CONFERENCE (Same date as above)	
9:00 a.m. (PDT)	10:00 a.m. (MDT)
Northern Idaho DHW Office 1120 Ironwood Drive Lower Level - Suite 102 Large Conference Room Coeur d’Alene, ID 83814	Eastern Idaho DHW Office 1070 Hiline Road (Brown Brick Building) Second Floor - Suite 230 Pocatello, ID 83201

The hearing sites will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking revises the reimbursement rate setting methodology for the following types of home and community-based service providers:

1. Developmental Disability Agencies (serving adults and children);
2. Residential Habilitation Agencies;
3. Supported Employment Agencies; and
4. Targeted Service Coordinators.

NOTE: The substantive changes made in this docket have been negotiated over the last two years with providers of home and community-based services across the state of Idaho. Rather than going pending under this docket number, the Department intends for these changes to go pending in the Department’s non-fee Omnibus Docket No. 16-0000-1900 that will publish in the Special Edition of the *Idaho Administrative Bulletin* on Wednesday, November 20, 2019.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year resulting from this rulemaking:

There is no anticipated fiscal impact for this rulemaking to the State General Fund, or any other funds. Although future reimbursement rates for the specified providers will be impacted by this rule change, the impact cannot be estimated at this time. Any revisions to provider reimbursement rates will be based on future cost survey data and wage data, and any necessary funding will be requested in accordance with the state budget development and appropriation processes.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 5, 2019, Idaho Administrative Bulletin, **Vol. 19-6, pages 57-58.**

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Karen Westbrook, (208) 364-1960. Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2019.

Dated this 19th day of August, 2019.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5564
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E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0310-1704
(Only Those Sections With Amendments Are Shown.)

037. GENERAL REIMBURSEMENT: PARTICIPANT SERVICES.

The Department will evaluate provider reimbursement rates that comply with 42 U.S.C. 1396a(a)(30)(A). This evaluation will assure payments are consistent with efficiency, economy, and quality of care and safeguards against unnecessary utilization of care and services. Reimbursements will be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. (4-4-13)

01. Applicable Participant Services. Unless otherwise provided in this chapter of rules, the following types of services are reimbursed as provided in this rule: ()

a. The Personal Care Services (PCS) described in Sections 300-308 of these rules. ()

b. The Aged and Disabled Waiver services described in Sections 320-330 of these rules. ()

c. The Children’s Developmental Disabilities Home and Community-Based State Plan Option Services described in Sections 520-528 of these rules. ()

d. The Adult Developmental Disabilities Waiver services described in Sections 700-706 of these rules. ()

e. The Adult Developmental Disabilities Home and Community-Based State Plan Option Services described in Sections 645-657 of these rules. ()

042. Review Reimbursement Rates. The Department will review provider reimbursement rates and conduct cost surveys when an access or quality indicator reflects a potential access or quality issue described in Subsections 037.02 and 037.03 of this rule. (4-4-13)()

023. Access. The Department will review annual statewide and regional access reports by service type comparing the previous twelve (12) months to the base-line year of State Fiscal Year 2012. The following measures will be used to determine when there is potential for access issues. (4-4-13)

a. Compare the change in total number of provider locations for service type to the change in eligible participants; or (4-4-13)

b. When participant complaints and critical incidence logs reveal outcomes that identify access issues for a service type. (4-4-13)

034. Quality. The Department will review quality reports required by each program used to monitor for patterns indicating an emerging quality issue. (4-4-13)

045. Cost Survey. The Department will survey one hundred percent (100%) of providers. Providers that refuse or fail to respond to the periodic state surveys may be disenrolled as Medicaid providers. The Department will derive reimbursement rates using direct care staff costs, employment related expenditures, program related costs, and indirect general and administrative costs in the reimbursement methodology, when these costs are incurred by a provider. The Department will conduct cost surveys customized for each of the services defined identified in Section 038 of these rules. (4-4-13)()

a. Wage rates will be used in the reimbursement methodology when the expenditure is incurred by the provider type executing the program. Wages will be identified in the Bureau of Labor Statistics website at www.bls.gov when there is a comparable occupation title for the direct care staff. When there is no comparable occupation title for the direct care staff, then a weighted average hourly rate methodology will be used. (4-4-13)

b. For employer related expenditures: (4-4-13)

i. The Bureau of Labor Statistics' report for employer costs per hour worked for employee compensation and costs as a percent of total compensation for Mountain West Divisions will be used to determine the incurred employer related costs by each provider type. The website for access to this report is at www.bls.gov. (4-4-13)

ii. The Internal Revenue Service employer cost for social security benefit and Medicare benefit will be used to determine the incurred employer related costs by provider type. The website for access to this information is at www.irs.gov. (4-4-13)

c. Cost surveys to collect indirect general, administrative, and program related costs will be used when these expenditures are incurred by the provider type executing the program. The costs will be ranked by costs per provider, and the Medicaid cost used in the reimbursement rate methodology will be established at the seventy-fifth percentile in order to efficiently set a rate. (4-4-13)

038. ~~GENERAL REIMBURSEMENT: TYPES OF PARTICIPANT~~ SPECIALIZED REIMBURSEMENT: CERTAIN HOME AND COMMUNITY-BASED SERVICES.

The following types of services are reimbursed as provided in Section 037 of these rules. The Department will review provider reimbursement rates to ensure compliance with 42 U.S.C. 1396a(a)(30)(A). This review will assure payments are consistent with efficiency, economy, quality of care, and safeguard against unnecessary utilization of care and services. Reimbursements will be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. (4-4-13)()

01. ~~Personal Care~~ **Applicable Home and Community-Based Services**. The ~~fees for personal care services (PCS) described in Section 300 of these~~ home and community-based services provided by the following types of providers are reimbursed as described in this rule: ~~(4-4-13)~~ ()

- a. Developmental Disability Agencies providing services to adults; ()
- b. Developmental Disability Agencies providing services to children; ()
- c. Residential Habilitation Agencies; ()
- d. Supported Employment Agencies; and ()
- e. Targeted Service Coordination Agencies. ()

02. ~~Aged and Disabled Waiver Services~~ **Timing, Description, and Results of Rate Reviews**. The ~~fees for personal care services (PCS) described in Section 320 of these rules.~~ ~~(4-4-13)~~ ()

a. Standard Rate Reviews. The Department will conduct a cost survey and review reimbursement rates at least once every five (5) years for each type of provider specified in this rule. Cost surveys will be conducted in the order and on the schedule established by the Department. ()

b. Interim Rate Reviews. The Department will prepare an annual trigger analysis and publish the report on its Medicaid Providers webpage, <http://healthandwelfare.idaho.gov/Providers/MedicaidProviders/tabid/214/Default.aspx>. This annual report will describe the triggers for interim rate review, a summary of the data reviewed for each trigger, and the Department's determination and rationale of whether each trigger was met. The Department will conduct an interim rate review upon the occurrence of one (1) or more of the following triggers: ()

i. When substantiated participant complaints, critical incidents, or both, related to a lack of qualified providers indicate an emerging access issue; ()

ii. When quality reports prepared by the Department or substantiated participant complaints and critical incidents related to the quality of services provided indicate an emerging quality issue; or ()

iii. When the federal or Idaho state minimum wage requirement in effect at the time of the standard rate review significantly increases or decreases. ()

c. No Obligation to Revise Rates. The Department is not required to revise reimbursement rates each time a rate review or cost survey is conducted. The results of a rate review or cost survey do not guarantee a change to the reimbursement rate. ()

03. ~~Children's Waiver Services~~ **Cost Survey Procedures**. The ~~fees for children's waiver services described in Section 680 of these rules.~~ ~~(4-4-13)~~ ()

a. Participation. The Department will survey one hundred percent (100%) of providers. A provider who refuses or fails to respond to the periodic cost surveys may be disenrolled as a Medicaid provider. ()

b. Customization. The Department will conduct cost surveys customized for each type of provider identified in this rule. ()

c. Independent Consultant. The Department will engage an independent cost survey consultant with expertise and experience in fee-for-service home and community-based services, including services for individuals with developmental disabilities. ()

d. Provider Engagement. ()

i. The Department will establish reimbursement advisory workgroups to advise on matters related to

the specialized reimbursement specified in this rule, including notice and development of cost surveys, recommendation of Bureau of Labor and Statistics occupation profile or profiles utilized when setting new reimbursement rates, and other reimbursement-related matters presented by the Department. The Department will retain final decision-making authority over all matters presented to or reviewed by the workgroups. ()

ii. The Department will provide reasonable prior notice of pending cost surveys to impacted providers. ()

iii. The Department or its cost survey consultants will train providers how to complete the cost survey, and provide technical assistance to providers during the cost survey response period. ()

04. ~~Adults with Developmental Disabilities Waiver Services~~ Reimbursement Rate Setting Methodology. The fees for adults with developmental disabilities waiver services described in Section 700 of these rules. Reimbursement rates will be derived using a combination of four (4) cost components - direct care staff wages or targeted service coordinator wages, employee-related expenses, program-related expenses, and general and administrative expenses. Each provider must demonstrate that the average percent of wage and benefits paid to their direct care staff (or targeted service coordinators) meets or exceeds the percent of wages and employee-related expenses utilized in establishing the reimbursement rate for the service type. The cost components and new reimbursement rate are established in accordance with the following: (4-4-13)()

a. Direct Care Staff Wages and Targeted Service Coordinator Wages. ()

i. Direct care staff and targeted service coordinator wages are wages paid to individuals employed or contracted by an agency who perform duties described in the applicable service coverage description for at least seventy-five percent (75%) of the total annual amount of time they are compensated. ()

ii. The wage component (Wage) used to establish the new reimbursement rate is set using the mean hourly wage of one (1) or more occupation profiles from the most current Bureau of Labor and Statistics (BLS) State Occupational Employment and Wage Estimates table for the state of Idaho found on the BLS website at www.bls.gov. The BLS occupation profile that most closely aligns with the duties, education level, and supervision requirements of the direct care staff (or targeted service coordinator) providing the service is utilized. If more than one (1) occupation profile aligns with the duties, education level, and supervision requirements of the direct care staff (or the targeted service coordinator) providing the service, then a weighted average of the mean hourly wage of multiple BLS occupation profiles is utilized. ()

iii. When there is no comparable occupation profile or profiles for the direct care staff (or targeted service coordinator), then the wage component used to establish the new reimbursement rate is set using the weighted average hourly rate (WAHR) of the surveyed wages included in the final cost survey results. ()

iv. The Department will make the final determination of BLS occupation profile or profiles after consideration of advice from the relevant Reimbursement Advisory Workgroup. ()

v. The Department will evaluate an appropriate wage inflation factor based on the economic data available at the time the reimbursement rate is set. ()

b. Employee-Related Expenses (ERE). ()

i. ERE are the expenses incurred by the provider agency for the benefit of the direct care staff (or targeted service coordinators) of an agency in the following six (6) categories: (1) paid leave, (2) supplemental pay, (3) payroll taxes, (4) workers' compensation, (5) insurance coverage, and (6) retirement contributions. ()

ii. The ERE component percentage (ERE%) used to establish the new reimbursement rate is set using the cumulative percentage of employer costs for employee compensation from the most current BLS Employer Costs for Employee Compensation table for the West Region in the Mountain Division and IRS Publication 15. ()

c. Program-Related Expenses (PRE). ()

i. PRE are wages and other expenses that support the objectives and provision of the service but cannot be tied to any particular person receiving the service. Requirements related to the delivery of services in accordance with statute and rule are PRE. ()

ii. Program-related staff are individuals employed by an agency who perform program-related duties as required by statute or rule for at least seventy-five percent (75%) of the total annual amount of time they are compensated. ()

iii. Utilizing data in the final cost survey results, each agency's PRE component percentage (PRE%) is calculated by dividing the agency's total PRE by the agency's total wages. Each agency's PRE% is ranked, and the PRE% used to calculate the new reimbursement rate is set at the mean of the agency PRE%. ()

d. General and Administrative (G&A) Expenses. ()

i. G&A expenses are wages and other expenses related to day-to-day operations common across all businesses. ()

ii. G&A staff are individuals employed by an agency who perform administrative duties for at least seventy-five percent (75%) of the total annual amount of time they are compensated. ()

iii. Utilizing data in the final cost survey results, each agency's G&A component percentage (G&A%) is calculated by dividing the agency's total G&A expenses by the sum of the agency's total wages, plus the total ERE, plus the total PRE, plus the total G&A expenses. Each agency's G&A% is ranked, and the G&A% used to calculate the new reimbursement rate is set at the mean of the agency G&A%. ()

iv. The G&A% used to calculate the new reimbursement rate will not exceed ten percent (10%) of the total reimbursement rate per staff hour. ()

e. Total Reimbursement Rate Per Staff Hour of Service = ((Wage + (ERE% x Wage) + (PRE% x Wage)) / (1 - (G&A%))). ()

f. The Department is not obligated to make budget requests based on the total reimbursement rate per staff hour. The Department will take into consideration the factors of efficiency, economy, quality of care, and access to care when determining rates. Reimbursement rates may be set at a percentage of the total reimbursement rate per staff hour. All reimbursement rate increases are subject to approval by the Idaho State Legislature. ()

~~05. Service Coordination—Quality Performance Incentives. The fees for service coordination described in Section 720 of these rules.~~ (4-4-13)()

a. Based on the quality of services provided to its Medicaid participants, a provider may become eligible to receive incentive payments. ()

b. Quality measures and associated payment percentages will be established by the Department, in collaboration with the Idaho Council on Developmental Disabilities and DisAbility Rights Idaho (or such other organization designated by the Governor as the state's protection and advocacy system), and will be described in the Idaho Medicaid Provider Handbook available at www.idmedicaid.com. The Department will provide sixty (60) days prior notice of any substantive changes to the quality measures and associated payment percentages described in its provider handbook. ()

c. Incentive payments will be subject to the availability of State and federal funds, and may be rescinded if the quality of services declines. ()

~~06. Therapy Services. The fees for physical therapy, occupational therapy, and speech language pathology services described in Section 215 of these rules include the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the client for the use of such equipment.~~ (4-4-13)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.18 – MEDICAID COST-SHARING

DOCKET NO. 16-0318-1901

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b), 56-253 and 56-257, Idaho Code, and Title XIX and Title XXI of the Social Security Act.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

PUBLIC HEARING
Tuesday, October 8, 2019 1:30 - 3:30 p.m. (MDT)
Medicaid Central Office 3232 Elder Street Conference Room D East Boise, ID 83702
WebEx Information:

Meeting Link for Attendees:

<https://idhw.webex.com/idhw/j.php?MTID=ma4ba5ad0a61ba17b701d8394be342ebe>

Event Number (access code): 808 771 218

**Meeting Password: aeeqfSBw
(23373729 from phones and video systems)**

The hearing site will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The proposed rulemaking proposes to align the Personal Needs Allowance (PNA) for all HCBS participants regardless of marital status. This alignment also allows the Department to reduce the PNA table from six (6) categories of eligibility down to two (2). The final determination of this rule change will align the PNA for all participants without a rent or mortgage expense to 100% of the Federal SSI benefit.

Additionally, a subsection has been added that details that Native Americans and Medicaid Workers with Disabilities are exempt from this share of cost requirement. 42 CFR 447.56 prohibits states from collecting share of cost from Tribal participants and MWD participants. This update is necessary to help align this chapter with other rule chapters, CFR, and clarify existing practice. While this is an addition to this rule, it also provides a clarification to this chapter that has been a source of confusion for participants and providers of HCBS services.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year as a result of this rulemaking:

Aligning the Personal Needs allowance (PNA) to 100% of SSI Federal benefit results in a net impact of an ongoing savings of \$296,726 (approximately \$207,708 Federal dollars and \$89,018 State dollars) per year due to a reduction in Medicaid claims expenditures. The change will result in Share of Cost increasing for a small number of

participants (191 members in State Fiscal Year 2018 and approximately 30 members as of August 5, 2019) receiving Home and Community Based Services, which will decrease the amount of dollars paid in Medicaid claims.

Funding sources: Aligning the PNA to 100% of SSI Federal benefit results in a net impact of an ongoing savings of \$296,726 (approximately \$207,708 Federal dollars and \$89,018) per year due to a reduction in Medicaid claims expenditures.

Automated Systems: There is no fiscal impact associated with changes to automated systems, the Idaho Benefit Eligibility System (IBES). Necessary changes will be incorporated into routine business operations and required annual updates will be made.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules – Negotiated Rulemaking was published in the June 5, 2019, Idaho Administrative Bulletin, [Vol. 19-6, pages 59-60](#).

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jennifer Pinkerton, (208) 287-1171.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 23, 2019.

Dated this 19th day of August, 2019.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5564
Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

**THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0318-1901
(Only Those Sections With Amendments Are Shown.)**

025. PARTICIPANTS EXEMPT FROM COST-SHARING.

Native American and Alaskan Native participants are exempt from the cost-sharing provisions of Sections 200, 205, 215, ~~and 320~~, and 400 of these rules. The participant must declare his race to the Department to receive this exemption. Participants in the Medicaid Workers with Disabilities (MWD) program are exempt from the cost-sharing provisions of Sections 200, 205, 207, and 400 of these rules. ~~(3-21-12)()~~

(BREAK IN CONTINUITY OF SECTIONS)

215. PREMIUMS FOR PARTICIPATION IN MEDICAID ENHANCED PLAN.

01. Workers with Disabilities. A participant in the Medicaid for Workers with Disabilities coverage group must share in the cost of Medicaid coverage, if required. Countable income is determined under IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." A participant's premium for his share of Medicaid costs under this coverage group is determined in Subsections 215.02 through 215.04 of this rule. (3-19-07)

~~**02a. Countable Income at or Below 133%.**~~ A participant who has countable income at or below one hundred thirty-three percent (133%) of the current federal poverty guideline is not required to pay a premium for Medicaid. (3-19-07)

~~**03b. Countable Income Above 133% to 250%.**~~ A participant who has countable income above one hundred thirty-three percent (133%) to two hundred fifty percent (250%) of the current federal poverty guideline is required to pay a monthly premium of ten dollars (\$10) to the Department. (3-19-07)

~~**04c. Countable Income in Excess of 250%.**~~ A participant who has countable income in excess of two hundred fifty percent (250%) of the current federal poverty guideline is required to pay a monthly premium to the Department. The amount due is the greater of ten dollars (\$10); or seven and one-half percent (7.5%) of the participant's income above two hundred fifty percent (250%) of the current federal poverty guideline. (3-19-07)

052. Recomputed Premium Amount. Premium amounts are recomputed when changes to a participant's countable income result in a different percentage premium calculation as determined in Subsections 215.02 through 215.04 of this rule, and at the annual re-determination. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

400. PARTICIPATION IN THE COST OF HOME AND COMMUNITY-BASED WAIVER SERVICES. Medicaid participants required to participate in the cost of Home and Community-Based Waiver (HCBS) services as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," must have their share of cost determined as described in Subsections 400.01 through 400.10 of this rule. (3-19-07)

01. Excluded Income. Income excluded under the provisions of IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Sections 723 and 725, is excluded in determining participation. (3-19-07)

02. Base Participation. Base participation is income available for participation after subtracting all allowable deductions, except for the incurred medical expense deduction in Subsection 400.07 of this rule. Base participation is calculated by the participant's Self Reliance Specialist. The incurred medical expense deduction is calculated by the ~~Regional Medicaid Services (RMS)~~ Division of Welfare. (3-19-07)()

03. Community Spouse. Except for the elderly or physically disabled participant's personal needs allowance, base participation for a participant with a community spouse is calculated under IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 725. A community spouse is the spouse of an HCBS participant who is not an HCBS participant and is not institutionalized. The HCBS personal needs allowance for a participant living in adult residential care equals the federal Supplemental Security Income (SSI) benefit rate for an individual living independently. (3-19-07)

04. Home and Community Based Services (HCBS) Spouse. Except for the elderly or physically disabled participant's personal needs allowance (PNA), base participation for a participant with an HCBS spouse is calculated and specified under IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 723. An HCBS spouse is the spouse of a participant who also receives HCBS. (3-19-07)

05. Personal Needs Allowance. The participant's personal needs allowance depends on ~~his marital status and whether the participant has a~~ legal obligation to pay rent or mortgage. The participant's personal needs allowance is deducted from ~~his~~ any countable income after income exclusions and before other allowable deductions. To determine the amount of the personal needs allowance, use Table 400.05 of this rule:

TABLE 400.05 - PERSONAL NEEDS ALLOWANCE			
Amount of Personal Needs Allowance (PNA) for Participation			
Not Responsible for Rent or Mortgage		Responsible for Rent or Mortgage	
<i>Marital Status</i>	PNA	<i>Marital Status</i>	PNA
<i>No Spouse</i>	One hundred percent (100%) of the federal SSI benefit for a person with no spouse	<i>No Spouse</i>	One hundred and eighty percent (180%) of the Federal SSI benefit for a person with no spouse
<i>Married with Community Spouse</i>	One hundred and fifty percent (150%) of the Federal SSI benefit for a person with no spouse	<i>Married with Community Spouse</i>	One hundred and eighty percent (180%) of the Federal SSI benefit for a person with no spouse
<i>Married with HCBS Spouse</i>	One hundred percent (100%) of the Federal SSI benefit for a person with no spouse. Each spouse receives this amount as his PNA.	<i>Married with HCBS Spouse</i>	One hundred and eighty percent (180%) of the Federal SSI benefit for a single person. Each spouse receives this amount as his PNA.

(3-29-17)()

06. Developmentally Disabled Participants. These allowances are specified in IDAPA 16.03.05, “Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD).” The HCBS personal needs allowance for adult participants receiving waiver services under the Developmentally Disabled Waiver is three (3) times the federal SSI benefit amount to an individual in his own home. (3-19-07)

07. Incurred Medical Expenses. Amounts for certain limited medical or remedial services not covered by the Idaho Medicaid Plan and not paid by a third party may be deducted from the base participation amount. The Department must determine whether a participant’s incurred expenses for such limited services meet the criteria for deduction. The participant must report such expenses and provide verification in order for an expense to be considered for deduction. Costs for over-the-counter medications are included in the personal needs allowance and will not be considered a medical expense. Deductions for necessary medical or remedial expenses approved by the Department will be deducted at application, and changed, as necessary, based on changes reported to the Department by the participant. (3-19-07)

08. Remainder After Calculation. Any remainder after the calculation in Subsection 400.05 of this rule is the maximum participation to be deducted from the participant's provider payments to offset the cost of services. The participation amount will be collected from the participant by the provider. The provider and the participant will be notified by the Department of the amount to be collected. (3-19-07)

09. Recalculation of Participation. The participant’s participation amount must be recalculated annually at redetermination or whenever a change in income or deductions becomes known to the Department. (3-19-07)

10. Adjustment of Participation Overpayment or Underpayment Amounts. The participant’s participation amount is reduced or increased the month following the month the participant overpaid or underpaid the provider. (3-19-07)