Dear Senators VANORDEN, Zuiderveld, Wintrow, and
Representatives VANDER WOUDE, Erickson, Chew:

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

IDAPA 16.03.13 - Consumer-Directed Services - Temporary and Proposed Rule (Docket No. 16-0313-2101);

IDAPA 16.03.18 - Medicaid Cost-Sharing (ZBR Chapter Rewrite, Fee Rule) - Proposed Rule (Docket No. 16-0318-2301).

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 10/27/2023. 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 11/24/2023.

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.

Terri Kondeff
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: Senior Legislative Drafting Attorney - Jill Randolph

DATE: October 10, 2023

SUBJECT: Department of Health and Welfare

IDAPA 16.03.13 - Consumer-Directed Services - Temporary and Proposed Rule (Docket No. 16-0313-2101)

IDAPA 16.03.18 - Medicaid Cost-Sharing (ZBR Chapter Rewrite, Fee Rule) - Proposed Rule (Docket No. 16-0318-2301)

Summary and Stated Reasons for the Rule

Docket No. 16-0313-2101: The agency submits notice of a temporary and proposed rule at IDAPA 16.03.13. This docket makes technical corrections and implements operations for the end of the COVID-19 public health emergency. This rule also includes updates to comply with the K.W. Settlement and changes to align with federal regulations. The Department states the reasons for this proposed and temporary rule include decreasing regulatory burden and updating rules to comply with governing law.

Docket No. 16-0318-2301: The agency submits notice of proposed rulemaking at IDAPA 16.03.18. The Department notes this is a Zero-Based Regulation ("ZBR") chapter rewrite pursuant to Executive Order 2020-01. Accordingly, the Department states this rulemaking is intended to streamline and simplify existing rules previously submitted and reviewed by the Legislature regarding cost-sharing requirements for clients of Medicaid. The Department states no fees are increased and no new fees are imposed by the rulemaking.

Negotiated Rulemaking / Fiscal Impact

Docket No. 16-0313-2101: The agency states that negotiated rulemaking was conducted and the Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the November 3, 2021 edition of the Idaho Administrative Bulletin. The agency states that a delay in federal approval of changes delayed the submission of these proposed rules for review by the Legislature. The agency further states that only those portions of the 2021 negotiated rulemaking that do not required federal approval are included in these temporary and proposed rules. There is no anticipated negative impact to the General Fund. The Governor finds the temporary rule is appropriate because it confers a benefit, aligns the rules with governing law, and is for the protection of the public health, safety, and wellbeing.

Docket No. 16-0318-2301: The agency states that negotiated rulemaking was conducted and the Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 3, 2023 edition of the Idaho

Administrative Bulletin. The rulemaking is not anticipated to have a negative fiscal impact on the General Fund.

Statutory Authority

The proposed rule appears to be authorized pursuant to Sections 56-202, 56-253, and 56-264, Idaho Code.

cc: Department of Health and Welfare
Frank Powell and Trinette 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

16.03.13 – CONSUMER-DIRECTED SERVICES

DOCKET NO. 16-0313-2101

NOTICE OF RULEMAKING – TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is September 1, 2023.

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 regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203, 56-253, and 56-264, Idaho Code.

PUBLIC HEARING SCHEDULE: Two public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCE Via WebEx

Wednesday, October 18, 2023
9:00 a.m. (MT)

Join from the meeting link:
https://idhw.webex.com/idhw/j.php?MTID=m22d7402b3e4f05b93a795b6ffd75471a

Join by meeting number:
Meeting number (access code): 2761 907 1160
Meeting password: fMMMepQE333 (36663773 from phones and video systems)

Join by phone:
+1-415-527-5035 United States Toll
+1-303-498-7536 United States Toll (Denver)

VIRTUAL TELECONFERENCE Via WebEx

Wednesday, October 18, 2023
2:00 p.m. (MT)

Join from the meeting link:
https://idhw.webex.com/idhw/j.php?MTID=m24d31b98e8d19db20a8af0d0505f54e6

Join by meeting number:
Meeting number (access code): 2760 176 3901
Meeting password: sVaHVstG774 (78248784 from phones and video systems)

Join by phone:
+1-415-527-5035 United States Toll
+1-303-498-7536 United States Toll (Denver)

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:

The following changes are made in conjunction with companion Docket No. 16-0310-2101, Medicaid Enhanced Plan Benefits.

This rule change will decrease regulatory burdens, make technical corrections, implement operations for the end of the public health emergency, update rules to comply with K.W. Settlement, and align with federal regulations regarding conflicts of interest.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1) (a), (b), and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

The changes in this rulemaking qualify for all the following purposes for a Temporary rulemaking:

(a) Protection of the public health, safety, or welfare; or
(b) Compliance with deadlines in amendments to governing law or federal programs; or
(c) Conferring a benefit.

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

This rulemaking and this chapter of rules do not contain any fees.

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:

There is no anticipated fiscal impact to the General Fund, state funds, or any other known funds.

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 November 3, 2021, Idaho Administrative Bulletin, Volume 21-11, pages 44-45.

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:

The documents incorporated by reference in these rules are not being changed in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact William Deseron at 208-859-0046.

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 25, 2023.

DATED this 1st day of September, 2023.

Trinette Middlebrook and Frank Powell
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
dhwrules@dhw.idaho.gov email

THE FOLLOWING IS THE TEMPORARY RULE AND THE PROPOSED TEXT OF DOCKET NO. 16-0313-2101
(Only Those Sections With Amendments Are Shown.)

009. ~~CRIMINAL HISTORY AND~~ BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department ~~Criminal History~~ Background Check. The fiscal employer agent must verify that each support broker and community support worker, whose ~~criminal history~~ background check has not been waived by the participant, has complied with IDAPA 16.05.06, "Criminal History and Background Checks." When a participant chooses to waive the ~~criminal history~~ background check requirement for a community support worker, the waiver must be completed in accordance with Section 150 of these rules. ~~Except, through the duration of the declared COVID-19 public health emergency, if each support broker and community support worker, whose criminal history check has not been waived by the participant is unable to complete a criminal background check in accordance with the timeframes set forth in IDAPA 16.05.06, then provider may allow newly hired direct care staff to begin rendering services prior to completion of the criminal background check in accordance with the requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx.~~ ~~(3-17-22)~~(9-1-23)T

02. Availability to Work or Provide Service. Participants~~, at their discretion,~~ may review the completed application and allow the community support worker to provide services on a provisional basis if no disqualifying offenses ~~listed in~~ under IDAPA 16.05.06, "Criminal History and Background Checks," are disclosed. ~~(3-17-22)~~(9-1-23)T

03. Additional Criminal Convictions. Once ~~criminal history~~ clearances have been received, any additional criminal convictions must be immediately reported by the worker to the participant and by the participant to the Department. ~~(3-17-22)~~(9-1-23)T

04. Notice of Pending Investigations or Charges. Once ~~criminal history~~ clearances have been received, any charges or investigations for abuse, neglect or exploitation of any vulnerable adult or child, criminal charges, or substantiated adult protection or child protection complaints, must be immediately reported by the worker to the participant and by the participant to the Department. ~~(3-17-22)~~(9-1-23)T

05. Providers Subject to ~~Criminal History~~ Background Check Requirements. A community support worker, who has not had the requirement waived by the participant, and a support broker as defined in Section 010 of these rules. ~~(3-17-22)~~(9-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

135. SUPPORT BROKER REQUIREMENTS AND LIMITATIONS.

01. Initial Application to Become a Support Broker. Individuals interested in becoming a support broker must complete the Department-approved application to document that they: (3-17-22)

a. ~~Is~~Are eighteen (18) years of age or older; ~~(3-17-22)~~(9-1-23)T

b. ~~Has~~Have skills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field; and ~~(3-17-22)~~(9-1-23)T

c. ~~Has~~Have at least two (2) years verifiable experience with the target population and knowledge of services and resources in the developmental disabilities field. ~~(3-17-22)~~(9-1-23)T

02. Application Exam. Applicants that meet the minimum requirements ~~outlined in~~ under this ~~section~~ rule will receive training materials and resources to prepare for the application exam. Under Family-Directed Community Supports (FDCS), children's support brokers must attend the initial training. Applicants must earn a score of seventy percent (70%) or higher to pass. Applicants may take the exam up to three (3) times. After the third time, the applicant will not be allowed to retest for twelve (12) months from the date of the last exam. Applicants who pass the exam, and meet all other requirements ~~outlined in~~ under these rules, will be eligible to enter into a provider agreement with the Department. ~~Through the duration of the COVID-19 public health emergency, support brokers may begin rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx.~~ ~~(3-17-22)~~(9-1-23)T

03. Required Ongoing Training. All support brokers must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of support broker services. Up to six (6) hours of the required twelve (12) hours may be obtained through independent self-study. The remaining hours must consist of classroom training. (3-17-22)

04. Termination. The Department may terminate the provider agreement when the support broker: (3-17-22)

a. Is no longer able to pass a ~~criminal history~~ background check ~~as outlined in~~ under Section 009 of these rules. ~~(3-17-22)~~(9-1-23)T

b. Puts the health or safety of the participant at risk by failing to perform job duties ~~as outlined in~~ under the employment agreement. ~~(3-17-22)~~(9-1-23)T

c. Does not receive and document the required ongoing training. (3-17-22)

05. Limitations. The support broker must ~~not~~: ~~(3-17-22)~~(9-1-23)T

a. Not ~~P~~provide, or be employed by an agency that provides paid community supports under Section 150 of these rules to the same participant; and ~~(3-17-22)~~(9-1-23)T

b. For Self-Directed Community Supports (SDCS), ~~be the guardian, parent, spouse, payee, or conservator of the participant, or have direct control over the participant's choices. Additionally, the support broker must not be in a position to both influence a participant's decision making and receive undue financial benefit from the participant's decisions~~ meet the conflict of interest standards under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~(3-17-22)~~(9-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

190. INDIVIDUALIZED BUDGET.

The Department ~~sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to the participant's assessed needs. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. The participant must work within the identified budget and acknowledge that they understand the budget figure is a fixed amount.~~ will assign budgets based on the criteria under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~(3-17-22)~~(9-1-23)T

01. Budget Amount Notification. The Department notifies each participant of their set budget amount as part of the eligibility determination or annual redetermination process. The notification will include how the participant may appeal the set budget amount. (3-17-22)

02. Annual Re-Evaluation of Adult Individualized Budgets. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's condition that results in a need for services that meet medical necessity criteria, and that is not reflected on the current inventory of individual needs. (3-17-22)

03. Annual Re-Evaluation of Children's Individualized Budgets. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes that may support placement in a different budget category ~~as identified in~~ under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 527. ~~(3-17-22)~~(9-1-23)T

(BREAK IN CONTINUITY OF SECTIONS)

302. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: CUSTOMER SERVICE.

01. Customer Service System. The provider must provide a customer service system to respond to all inquiries from participants, employees, agencies, and vendors. The provider must: (3-17-22)

a. Provide staff with customer service training with an emphasis on consumer-direction. (3-17-22)

b. Ensure staff are trained and have the skills to assist participants with enrollment and to help them understand their account statements. (3-17-22)

c. Ensure that fiscal employer agent personnel are available during regular business hours~~, 8 a.m. to 5 p.m. Mountain Time, Monday through Friday, excluding state holidays~~. ~~(3-17-22)~~(9-1-23)T

d. Provide translation and interpreter services (i.e., American Sign Language and services for persons with limited English proficiency). (3-17-22)

e. Provide prompt and consistent response to verbal and written communication. Specifically: (3-17-22)

i. All calls and voice mails ~~messages~~ must be responded to within one (1) business day; and ~~(3-17-22)~~(9-1-23)T

ii. All written and electronic correspondence must be responded to within five (5) business days. (3-17-22)

f. Maintain a toll-free phone line where callers speak to a live person during business hours and are provided the option to leave voice mail at any time, all day, every day. (3-17-22)

g. Maintain a toll-free fax line that is available all day, every day, exclusively for participants and their employees. (3-17-22)

02. Complaint Resolution and Tracking System. The provider is responsible for receiving, responding to, and tracking all complaints from any source under this agreement. A complaint is defined as a verbal or written expression of dissatisfaction about fiscal employer agent services. The provider must: (3-17-22)

a. Respond to all written and electronic correspondence within five business (5) days. ~~(3-17-22)~~(9-1-23)T

b. Respond to ~~verbal complaints~~ all calls and voicemails within one (1) business day. ~~(3-17-22)~~(9-1-23)T

c. Maintain an electronic tracking system and log of complaints and resolutions. The electronic log of

complaints and resolutions must be accessible for Department review through the SFTP site. (3-17-22)

d. Log and track complaints received from the Department pertaining to fiscal employer agent services. (3-17-22)

e. Compile a summary report and analyze complaints received on a quarterly basis to determine the quality of services to participants and to identify any corrective action necessary. (3-17-22)

f. Post the complaint to the SFTP site within twenty-four (24) hours any day a complaint is received Monday through Friday. Saturday and Sunday complaints must be posted to the SFTP site by close of business the following Monday. Failure to comply will result in a fifty dollar ($50) penalty payable to Medicaid within ninety (90) days of incident. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

310. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: PERFORMANCE METRICS.
The provider must do the following: (9-1-23)T

01. Readiness Review. ~~The provider must c~~Complete a readiness review conducted by the Department with the provider prior to providing fiscal employer agent services. ~~(3-17-22)~~(9-1-23)T

a. ~~Required Level of Expectation:~~ The provider must complete one hundred percent (100%) of the readiness review. ~~(3-17-22)~~(9-1-23)T

b. ~~Method of Monitoring:~~ The Department will access SFTP site for review of provider documents and conduct an onsite review. ~~(3-17-22)~~(9-1-23)T

02. Compliance with Tax Regulations and Labor Laws. ~~The provider must e~~Ensure each participant's compliance with regulations for both federal ~~taxes~~ and state taxes, ~~as well as~~ and all applicable labor laws. ~~(3-17-22)~~(9-1-23)T

03. Fiscal Support and Financial Consultation. (3-17-22)

a. The provider must provide each participant with fiscal support and financial consultation. (3-17-22)

b. ~~Required Level of Expectation:~~ The provider must respond to ninety-five percent (95%) of ~~participant~~ calls and voicemails within two (2) business days and to ~~e-mails~~ written and electronic correspondence within five business (5) days. ~~(3-17-22)~~(9-1-23)T

04. Federal and State Forms Submitted. ~~The provider must e~~Ensure each participant's compliance with regulations for both federal ~~taxes~~ and state taxes, including preparation and submission of all federal and state forms for each participant and their employees. ~~(3-17-22)~~(9-1-23)T

05. Mandatory Reporting, Withholding, and Payment. ~~The provider must p~~Perform all mandatory reporting, withholding, and payment actions according to the compliance requirements of the state and federal agencies. ~~(3-17-22)~~(9-1-23)T

06. Payroll Checks. ~~The provider must i~~Issue payroll checks within the two (2) week or semi-monthly payroll cycle, after receipt of completed, approved time sheets. ~~(3-17-22)~~(9-1-23)T

07. Adherence to Support and Spending Plan. ~~The provider must d~~Distribute payments to each participant employee ~~in accordance with~~ under the participant's support and spending plan. ~~(3-17-22)~~(9-1-23)T

08. Record Activities. ~~The provider must r~~Record all activities in an individual file for each participant

and their employees. ~~(3-17-22)~~(9-1-23)T

09. Records in Participant File. ~~The provider must m~~Maintain complete records in each participant's file. ~~(3-17-22)~~(9-1-23)T

10. Manage Phone, Fax, and E-Mail for Fiscal and Financial Questions. (3-17-22)

a. The provider must manage toll-free telephone line, fax, and e-mail related to participant fiscal and financial questions. (3-17-22)

b. ~~Required Level of Expectation:~~ The provider must respond to ninety-five percent (95%) of ~~participant queries~~ calls and voicemails within two (2) business days and to written and electronic correspondence within five (5) business days. ~~(3-17-22)~~(9-1-23)T

11. Track~~ing of~~ Complaints and Complaint Resolution. ~~(3-17-22)~~(9-1-23)T

a. The provider must maintain a register of complaints from participants, participant employees, and others, with corrective action implemented by the provider within one (1) business day of the complaint response. ~~(3-17-22)~~(9-1-23)T

b. ~~Required Level of Expectation:~~ The provider must respond to ninety-five percent (95%) of ~~complaints within one (1) business day~~ calls and voicemails within two (2) business days and to written and electronic complaints within five (5) business days. ~~(3-17-22)~~(9-1-23)T

12. Web Access to Electronic Time Sheet Entry. ~~The provider must m~~Maintain web access to electronic time sheet entry for participants. ~~(3-17-22)~~(9-1-23)T

13. Participant Enrollment Packets and Employment Packets. ~~The provider must p~~Prepare and distribute participant enrollment ~~packets~~ and employment packets to each participant. ~~(3-17-22)~~(9-1-23)T

14. Payroll Spending Summaries. ~~The provider must p~~Provide each participant with payroll spending summaries and information about how to read the payroll spending summary each time payroll is executed. ~~(3-17-22)~~(9-1-23)T

15. Quarterly Reconciliation. Each fiscal quarter after initiating service, the provider must reconcile its Medicaid Billing Report to a zero-dollar ($0) balance with the Medicaid Bureau of Financial Operations. The provider has ninety (90) days to comply with reconciling each participant's spending plan balance to a zero dollar ($0) balance with Medicaid's reimbursements. The provider must: ~~(3-17-22)~~(9-1-23)T

a. ~~Required Level of Expectation: The provider must h~~Have one hundred percent (100%) compliance with the required quarterly reconciliation of the Medicaid Billing Report. ~~(3-17-22)~~(9-1-23)T

b. ~~Strategy for Correcting Noncompliance: The provider must n~~Notify the Department immediately if an issue is identified that may result in the provider not reconciling the Medicaid Billing Report. The Department will notify the provider when a performance issue is identified. The Department may require the provider to submit a written corrective action plan for Department approval within two (2) business days after notification. If the provider fails to reconcile within ninety (90) days after the end of each quarter, the provider will be penalized fifty dollars ($50) each week until the provider has reconciled with Medicaid to a zero dollar ($0) balance. ~~(3-17-22)~~(9-1-23)T

16. Cash Management Plan. Each provider's cash management plan must equal one point five (1.5) times the monthly payroll cycle amount. ~~The cash management plan~~ and can be forms of liquid cash and lines of credit. For example, ~~in the case that the~~ if a provider's current payroll minimum has averaged one hundred thousand dollars ($100,000) per payroll cycle, the provider would be required to have one hundred fifty thousand dollars ($150,000) in a cash management plan. The Department must be ~~listed~~ on the notification list if any lines of credit are decreased in the amount accessible or terminated. The expectation is to provide a seamless payroll cycle to the participant, without loss of pay to their employees. ~~(3-17-22)~~(9-1-23)T

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.18 – MEDICAID COST-SHARING

DOCKET NO. 16-0318-2301 (ZBR CHAPTER REWRITE, FEE RULE)

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 42 CFR Part 447 Payments for services.

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

VIRTUAL TELECONFERENCE Via WebEx
Thursday, October 12, 2023 **9:00 a.m. - 10:00 a.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=maa22e58e051eda7333887306634fa3e9** **Join by meeting number** **Meeting number (access code): 2762 153 2942** **Meeting password: MSfpqxPp727 (67377977 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

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. Meeting(s) will conclude after 30 minutes if no participants sign in or wish to comment in the meeting.

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

Due to Executive Order 2020-01, Zero-Based Regulation, agencies are required to rewrite IDAPA chapters every 5 years on an approved schedule. This rulemaking is complying to this mandate and is scheduled for presentation to the 2024 Legislature. Under this Executive Order, the Department is rewriting this chapter of rules to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government while serving those receiving benefits subject to under Medicaid Cost-Sharing. This chapter rewrite is intended to perform a comprehensive review of this chapter in collaboration with the public to update, clarify, streamline, and simplify the rule language.

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

This chapter contains designation, records, and establishes a premium fee schedule for Youth Empowerment Services (YES) and SCHIP program participants. This chapter has no anticipated fee changes.

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:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

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 May 3, 2023, Idaho Administrative Bulletin Vol. 23-5, pages 150 through 151.

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:

There are no incorporations by reference in this chapter of rule.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cindy Brock at 208-364-1983 or Jennifer Pinkerton at 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 25, 2023.

DATED this 6th day of July, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
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e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF FEE DOCKET NO. 16-0318-2301
(ZBR Chapter Rewrite)

16.03.18 – MEDICAID COST-SHARING

000. LEGAL AUTHORITY.
Under Section 56-202(b), Idaho Code, ~~the Legislature has delegated to~~ the Department ~~of Health and Welfare the responsibility to~~ establishes and enforces ~~such~~ rules ~~as may be~~ necessary ~~or proper~~ to administer public assistance programs ~~within the state of Idaho~~. Under Sections 56-253, 56-255 and 56-257, Idaho Code, and 42 CFR Part 447 Payments for Service the Department ~~of Health and Welfare is to~~ establishes enforceable cost-sharing requirements within the limits of federal Medicaid law and regulations. ~~Furthermore, t~~The ~~Idaho~~ Department ~~of Health and Welfare~~ is the designated agency to administer programs under Title XIX and Title XXI of the Social Security Act.
~~(3-15-22)~~( )

~~**001. TITLE AND SCOPE.**~~

~~**01. Title**. These rules are titled IDAPA 16.03.18, "Medicaid Cost-Sharing."~~ ~~(3-15-22)~~

~~02. Scope.~~ ~~These rules describe the general requirements regarding the administration of the cost-sharing provisions for participation in a medical assistance program providing direct benefits in Idaho.~~ ~~(3-15-22)~~

~~002. WRITTEN INTERPRETATIONS.~~
~~This agency may have written statements which pertain to the interpretation of the rules of this chapter. These documents are available for public inspection.~~ ~~( )~~

00~~3~~2. -- 009. (RESERVED)

010. DEFINITIONS.
In addition to definitions under Section 56-252, Idaho Code, the following definitions apply: ( )

01. Copayment (Copay). The amount a participant ~~is required to~~ pays ~~to the~~ a provider for specified services. ~~(3-15-22)~~( )

~~02. Cost-Sharing. A payment the participant or the financially responsible adult is required to make toward the cost of the participant's health care. Cost-sharing includes both copays and premiums.~~ ~~(3-15-22)~~

~~03. Creditable Health Insurance. Creditable health insurance is coverage that provides benefits for inpatient and outpatient hospital services and physicians' medical and surgical services. Creditable coverage excludes liability, limited scope dental, vision, specified disease or other supplemental-type benefits.~~ ~~(3-15-22)~~

0~~4~~2. **Department**. The Idaho Department of Health and Welfare, or ~~a person authorized to act on behalf of the Department~~ its designee. ~~(3-15-22)~~( )

~~05. Family Income. The gross income of all financially responsible adults who reside with the participant, as calculated under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children."~~
~~(3-15-22)~~

~~06. Family Size. Family size is the number of people living in the same home as the child. This includes relatives and other optional household members.~~ ~~(3-15-22)~~

0~~7~~3. **Federal Poverty Guidelines (FPG)**. ~~The federal poverty g~~Guidelines issued annually by the U. S. Department of Health and Human Services (HHS)~~. The federal poverty guidelines are available on the U.S. Health and Human Services website~~ at ~~http://aspe.hhs.gov/poverty~~ http://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines. ~~(3-15-22)~~( )

~~08. Financially Responsible Adult. An individual who is the biological or adoptive parent of a child and is financially responsible for the participant.~~ ~~(3-15-22)~~

~~09. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended.~~ ~~(3-15-22)~~

~~10. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program.~~
~~(3-15-22)~~

~~11~~04. **Physician Office Visit**. Services ~~performed~~ provided to a participant by a physician, nurse practitioner, or physician's assistant ~~at the practitioner's place of business, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Indian Health Clinic/638 Clinics providing services to individuals eligible for Indian Health Services are not included~~. ~~(3-15-22)~~( )

~~12~~05. **Premium**. A regular and periodic charge or payment for health coverage. ( )

~~13. Social Security Act. 42 U.S.C. 101 et seq., authorizing, in part, federal grants to the states for medical assistance to eligible low-income individuals.~~ ~~(3-15-22)~~

~~14. State. The state of Idaho.~~ ~~(3-15-22)~~

~~15. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources.~~ (3-15-22)

~~16. Title XXI. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children.~~ (3-15-22)

011. -- 024. (RESERVED)

025. PARTICIPANTS NOT ALREADY FEDERALLY EXEMPT FROM COST-SHARING.
~~Native American and Alaskan Native participants are exempt from the cost-sharing provisions of Sections 200, 205, 215, 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. ~~(3-15-22)~~( )

026. -- 049. (RESERVED)

050. GENERAL COST-SHARING.

~~01. Cost-Sharing Maximum Amount. A family will be required to pay out of pocket costs not to exceed five percent (5%) of the family's anticipated gross monthly income unless an exception is made as provided in Subsection 050.02 of this rule.~~ (3-15-22)

~~02. Exception to Cost-Sharing Maximum. A family will be required to pay cost-sharing amounts as provided in Sections 215 and 400 of these rules. These cost-sharing amounts may exceed the family's five percent (5%) of anticipated gross monthly income.~~ (3-15-22)

0~~3~~1. **Proof of Cost-Sharing Payment**. If a participant believes ~~that~~ their cost-sharing exceeded ~~the~~ five percent (5%) ~~cost-sharing~~ of ~~the family's anticipated~~ gross monthly household income, they must provide proof to the Department ~~of the copay amounts that were paid~~ for an assessment of suspension or reimbursement. ~~(3-15-22)~~( )

0~~4~~2. **Excess Cost-Sharing**. A ~~family~~ household that establishes proof of payment for cost-sharing that exceeds ~~the~~ five percent (5%) of ~~the family's anticipated~~ gross monthly household income will be reimbursed by the Department for the amount paid that exceeds the five percent (5%), except as provided in ~~Subsection 050.02 of~~ this rule. ~~(3-15-22)~~( )

0~~5~~3. **Cost-Sharing Suspended**. A ~~family~~ household that exceeds the five percent (5%) maximum amount for cost-sharing ~~will~~ for the calendar month is not ~~be~~ required to pay ~~a~~ cost-sharing ~~portion~~ for any ~~family participant~~ household member for the remainder of the calendar month ~~in which proof of payment is established~~. ~~(3-15-22)~~( )

051. - 199. (RESERVED)

200. PREMIUMS FOR PARTICIPATION UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).

01. ~~Family~~ Household Income Above 133% of FPG. ~~Each SCHIP p~~Participants with ~~family~~ household income above one hundred thirty-three percent (133%) and equal to or less than one hundred fifty percent (150%) of the current FPG ~~must~~ pay a monthly premium of ten dollars ($10) to the Department. ~~(3-15-22)~~( )

02. ~~Family~~ Household Income Above 150% of FPG. ~~Each SCHIP p~~Participants with ~~family~~ household income above one hundred fifty percent (150%) and equal to or less than one hundred eighty-five percent (185%) of the current FPG ~~must~~ pay a monthly premium of fifteen dollars ($15) to the Department. ~~(3-15-22)~~( )

03. Premium Recalculation. Premiums are recalculated at each annual eligibility redetermination. If the Department receives verification of a reduction in household income prior to annual eligibility redetermination,

the premium is recalculated. The Department waives any premium for participants who become eligible for Title XIX Medicaid. ( )

04. Premium Reduction. The monthly premium for SCHIP participants may be reduced by ten dollars ($10) per month under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ( )

201. -- 204. (RESERVED)

205. PREMIUMS FOR PARTICIPATION UNDER HOME CARE FOR CERTAIN DISABLED CHILDREN (HCCDC).

01. ~~Family~~Household Income Above 150% and Equal to or Less Than 185% of FPG. ~~Each HCCDC p~~Participants with ~~a family~~ household income above one hundred fifty percent (150%) and equal to or less than one hundred eighty-five percent (185%) of the current FPG ~~must~~ pay a monthly premium of fifteen dollars ($15) ~~to the Department~~. The maximum monthly premium ~~a family must pay~~ is limited to thirty dollars ($30). ~~(3-15-22)~~( )

02. ~~Family~~Household Income Above 185% of FPG. ~~Each HCCDC family~~ Participants with income above one hundred eighty-five percent (185%) of the current FPG ~~must~~ pay a monthly premium ~~to the Department~~. The monthly premium is a fixed percentage of ~~the family's~~ household income as provided in the table below.

TABLE 205.02
SLIDING FEE SCHEDULE FOR MONTHLY PREMIUMS FOR HCCDC PARTICIPATION

~~Family~~Household Income Above 185% of Current FPG		Premium Based on % of ~~Family~~Household Income
ABOVE	LESS THAN OR EQUAL TO	
185%	250%	1.0%
250%	300%	1.5%
300%	400%	2.0%
400%	500%	2.5%
500%	600%	3.0%
600%	700%	3.5%
700%	800%	4.0%
800%	900%	4.5%
900%	No Upper Limit	5.0%

~~(3-15-22)~~( )

~~**03. Reduction of Premium for Creditable Health Insurance**. A family who purchases creditable health insurance for the participant may receive a twenty five percent (25%) reduction of the required monthly premium.~~ ~~(3-15-22)~~

043. Failure to Provide Information. Failure to provide the Department with information ~~needed~~ to

determine ~~family income and household size~~ eligibility may subject the participant to a monthly premium equal to the average monthly cost of coverage for participants receiving Medicaid Enhanced Plan Benefits through HCCDC. ~~(3-15-22)~~( )

0~~5~~4. **Failure to Pay Premium**. Failure to pay the premium ~~for an HCCDC participant~~ will not cause the participant to lose coverage or eligibility for services. ~~A participant eligible through HCCDC is exempt from the provisions of Section 250 of these rules.~~ ~~(3-15-22)~~( )

0~~6~~5. **Waiver of Premium**. The premium ~~may be~~ is waived if the Department determines ~~that~~ payment of the premium would cause undue hardship ~~on the family~~. Undue hardship exists when an unexpected expense would cause the ~~family~~ household to forgo basic food or shelter ~~in order~~ to make a premium payment. Detailed documentation of the ~~family's~~ household's living ~~and insurance~~ expenses demonstrating such hardship must be provided to the Department. ~~(3-15-22)~~( )

0~~7~~6. **Premium Recalculation**. ~~The~~ pPremiums ~~amount is~~ are recalculated at each annual eligibility ~~renewal~~ determination. If ~~a financially responsible adult reports a reduction in family income prior to renewal~~ the Department receives verification of a reduction in household income prior to annual redetermination, the premium ~~will be reduced to the appropriate level upon verification of the reduction to the family's income~~ is recalculated. ~~When the family income is at a level that does not require premium payments, the premium will no longer be assessed.~~ ~~(3-15-22)~~( )

206. (RESERVED)

207. PREMIUMS FOR PARTICIPATION UNDER THE YOUTH EMPOWERMENT SERVICES (YES) PROGRAM.

01. Premium Fee Schedule. ~~Each YES program p~~Participants~~, as that individual is defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 636, is~~ are subject to assessment of a premium ~~based on family income~~. The Department ~~will~~ establishes a premium fee schedule ~~at rates not to exceed maximums set forth in federal law and regulations governing state Medicaid programs. The fee schedule will be~~ that is published on the Department's website ~~and provided to families participating in the YES program who are subject to premiums~~ at https://healthandwelfare.idaho.gov/services-programs/medicaid-health. ~~(3-15-22)~~( )

~~**02. Enforcement of Premiums**. Payment of premiums will be enforced within the limitations of federal laws and regulations governing state Medicaid programs.~~ ~~(3-15-22)~~

0~~3~~2. **Waiver of Premium**. The monthly premium ~~described in Subsection 207.01 of~~ under this rule ~~may be~~ is waived if the Department determines ~~that~~ the ~~family~~ household is unable to participate in the cost of care. ~~(3-15-22)~~( )

0~~4~~3. **Premium Recalculation**. The premium amount is recalculated at each annual eligibility redetermination. ~~If a financially responsible adult reports a reduction in family income prior to eligibility redetermination, the premium will be reduced to the appropriate level upon verification of the reduction in the family's income. When the family income is reduced to a level that does not require premium payments, the premium will no longer be assessed.~~ ~~(3-15-22)~~( )

208. -- 209. (RESERVED)

210. DEPARTMENT RESPONSIBILITIES.

01. Assessed Premiums. A participant ~~will~~ is not ~~be~~ assessed premiums during the ~~time~~ initial eligibility ~~is~~ determin~~ed~~ation. Obligation for premium payments does not begin for at least sixty (60) days after receipt of application, except for workers with disabilities under ~~Section 215 of~~ these rules. ~~(3-15-22)~~( )

02. Premiums Not Assessed Due to Late Review. A participant cannot be assessed premiums for extra months of eligibility received due solely to the Department's ~~late~~ untimely review of continuing eligibility, except for workers with disabilities under ~~Section 215 of~~ these rules. ~~(3-15-22)~~( )

03. No Retroactive Premiums Assessed. A participant cannot be assessed premiums for months of retroactive eligibility. ( )

04. Notification of Premiums. The Department ~~is required to~~ routinely ~~notify~~ notifies ~~a~~ participants of their premium payment obligations including any delinquencies, if applicable. ~~(3-15-22)~~( )

211. -- 214. (RESERVED)

215. PREMIUMS FOR PARTICIPATION IN MEDICAID ~~ENHANCED PLAN~~ WORKERS WITH DISABILITIES.

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, "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 215.01.a. through 215.01.c. of this rule.~~ The monthly premium is a fixed percentage of countable income as provided on the Department's website at https://healthandwelfare.idaho.gov/services-programs/medicaid-health. ~~(3-15-22)~~( )

~~**a.** 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. (3-15-22)~~

~~**b.** 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. (3-15-22)~~

~~**c.** 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. (3-15-22)~~

02. 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. ~~(3-15-22)~~( )

216. -- 249. (RESERVED)

250. DELINQUENT PREMIUM PAYMENTS.
If the participant is sixty (60) days or more past due on ~~its~~ premium payments, the participant is contacted to determine the reason for the delinquency. If the participant's ~~countable~~ income is less than the amount used for the most recent eligibility determination, the participant is offered a new eligibility determination. ~~If a participant's family income is at a level that does not require premium payments, the premium will no longer be assessed.~~ The change is effective the month after the participant becomes eligible for such benefits. ~~The following Subsections 250.01 through 250.03 of this rule apply to delinquent premium payments.~~ ~~(3-15-22)~~( )

01. Delinquent Payments. A participant ~~must~~ is not ~~be~~ approved for or renewed for coverage that requires premium payments, if their premium payments are sixty (60) days or more delinquent ~~as of the last working day of their twelve (12) month eligibility period~~. ~~(3-15-22)~~( )

02. Reestablishing Eligibility. A participant can reestablish eligibility by paying the premium debt in full, unless ~~one (1) of the conditions listed in Subsection 250.03 applies~~ forgiven in this rule. ~~(3-15-22)~~( )

03. Premium Debt. Any premium debt assessed, but not paid, will be forgiven if one (1) of the following applies: ( )

a. The participant reports and the Department determines that the participant's ~~family~~ household income is below one hundred and thirty-three percent (133%) FPG. This may occur at any time during the eligibility

period; or ~~(3-15-22)~~( )

b. A participant in the Medicaid Basic Plan has a medical condition that requires the participant to receive the benefits provided in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~(3-15-22)~~( )

251. -- 299. (RESERVED)

300. PARTICIPANTS EXEMPT FROM COPAYMENT NOT ALREADY FEDERALLY EXEMPTED.
This includes participants who have other health care coverage that is the primary payor for the services provided.
( )

~~**01. Exempt Participants**. Certain participants are exempt from copayments for services described in Section 320.03 through 320.10 of these rules. Exempt participants include:~~ ~~(3-15-22)~~

~~**a.** A child under the age of nineteen (19) with family income less than or equal to one hundred and thirty-three percent (133%) of the current federal poverty guidelines (FPG);~~ ~~(3-15-22)~~

~~**b.** An individual age of nineteen (19) or older with family income less than or equal to one hundred percent (100%) of the current federal poverty guidelines (FPG);~~ ~~(3-15-22)~~

~~**c.** A pregnant or post-partum woman when the services provided are related to the pregnancy;~~ ~~(3-15-22)~~

~~**d.** An inpatient in a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities (ICF/IID), or other medical institution, who is required to pay all but a nominal amount of their income to the institution for their care;~~ ~~(3-15-22)~~

~~**e.** An adult participant who receives services provided under a waiver of Section 1915c of the Social Security Act (SSA);~~ ~~(3-15-22)~~

~~**f.** A participant who has other health care coverage that is the primary payor for the services provided;~~ ~~(3-15-22)~~

~~**g.** A participant receiving hospice care;~~ ~~(3-15-22)~~

~~**h.** A child in foster care receiving aid or assistance under the Social Security Act (SSA), Title IV, Part B;~~ ~~(3-15-22)~~

~~**i.** A participant receiving adoption or foster care assistance under the Social Security Act (SSA), Title IV, Part E, regardless of age; and~~ ~~(3-15-22)~~

~~**j.** A woman eligible under the breast and cervical cancer eligibility group.~~ ~~(3-15-22)~~

~~**02. Notification of Copayment**. The Department will provide notification to each participant who is not exempt from the copayment requirements in Subsections 320.03 through 320.10 of these rules.~~ ~~(3-15-22)~~

301. -- 309. (RESERVED)

310. COPAYMENT FEE AMOUNTS.

~~**01. Nominal Amount**. The amount of the copayment must be a nominal amount as provided in 42 CFR 447.54. This nominal amount is set by the U.S. Department of Health and Human Services.~~ ~~(3-15-22)~~

02. Fee Amount. Beginning on November 1, 2011, t~~T~~he ~~nominal~~ Copayment fee amount required to be paid by the participant ~~as a copayment~~, when applicable, is three dollars and sixty-five cents ($3.65). ~~This copayment amount will be adjusted annually as determined by the Secretary of Human Services.~~ ~~(3-15-22)~~( )

~~03. Annual Increase. The nominal fee amount will be increased annually by an adjusted percentage rate determined by the Secretary of Health and Human Services as set in the Social Security Act Section 1916.~~ ~~(3-15-22)~~

311. -- 319. (RESERVED)

320. ~~MEDICAID OUTPATIENT~~ SERVICES SUBJECT TO COPAYMENTS.
~~Medicaid p~~Participants are responsible for making copayments ~~for the outpatient services described in Subsections 320.01 through 320.10 of this rule,~~ unless otherwise exempt or exempted under this rule for the following. ~~The amount of the copayment is provided in Section 310 of these rules.~~ ~~(3-15-22)~~( )

01. Accessing Hospital Emergency Department for Non-Emergency Medical Conditions. ~~A participant who seeks care at a hospital emergency department for services that do not meet the definition of an emergency medical condition as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," may be required to pay a copayment to the provider. A participant who must access a hospital emergency department in order to receive routine services for their medical condition is exempt from this provision.~~ ~~(3-15-22)~~( )

02. Accessing Emergency Transportation Services for Non-Emergency Medical Conditions. ~~A participant who accesses emergency transportation services for a condition that is determined by the Department to be a non-emergency medical condition may be required to pay a copayment to the provider of the service.~~ ~~(3-15-22)~~( )

03. Chiropractic Services. ~~Those services for spinal manipulation performed by a chiropractor.~~ ~~(3-15-22)~~( )

04. Occupational Therapy, Speech or Physical. ~~(3-15-22)~~( )

05 Optometric Services. ~~Those services performed by an optometrist that fall into the "General Ophthalmological Services" category of Current Procedural Terminology (CPT).~~ ~~(3-15-22)~~( )

06. Outpatient Hospital Services. ~~Any of the services included in Subsections 320.03 through 320.05 and Subsections 320.07 through 320.10 of this rule performed in an outpatient hospital setting. Services performed in a Hospital Emergency Department are excluded, except as provided for in Subsection 320.01 of this rule.~~ ~~(3-15-22)~~( )

~~07. Physical Therapy.~~ ~~(3-15-22)~~

0~~8~~7. **Podiatry Services**. ~~Services provided by a podiatrist during an office visit.~~ ~~(3-15-22)~~( )

0~~9~~8. **Physician Office Visit**. Each physician office visit, unless the visit is for: ~~(3-15-22)~~( )

a. ~~The visit is for a~~A preventive service, including wellness exams, immunizations, or family planning~~.~~. ~~(3-15-22)~~( )

b. ~~The visit is for u~~Urgent care provided at a clinic billing as an urgent care facility. ~~(3-15-22)~~( )

~~10. Speech Therapy.~~ ( )

321. -- 324. (RESERVED)

325. EXCEPTION TO CHARGING A COPAYMENT.
~~In order for a copay to be charged by the provider, the Medicaid payment amount for the services rendered during a visit must be~~A provider may charge a copayment if the Medicaid reimbursement for the services rendered is equal to or greater than ten (10) times the amount of the copayment under ~~described in Section 310 of~~ these rules. ~~The Medicaid payment amount is determined by the Department and published in the Medicaid Fee Schedule.~~ ~~(3-15-22)~~( )

326. -- 329. (RESERVED)

330. COLLECTION OF COPAYMENTS.

01. Responsibility for Collection. The provider ~~of services~~ is responsible for collection of the copayment from the participant. ~~(3-15-22)~~( )

02. Denial of Services. The provider may require payment of ~~an~~ applicable copayment ~~prior to~~ before rendering services. ~~(3-15-22)~~( )

03. Waiver of Copayment. The provider may ~~choose to~~ waive payment of any copayment. The provider must have a written policy describing the criteria for waiving or enforcing collection of copayments ~~and when the copay may be waived~~. ~~(3-15-22)~~( )

04. Reduction in Reimbursement.When a copayment is applicable, the provider's reimbursement ~~will be~~ is reduced by the amount of the copayment regardless of whether ~~or not~~ a copayment was charged or collected by the provider. ~~(3-15-22)~~( )

331. -- 399. (RESERVED)

400. PARTICIPATION IN THE COST OF HOME AND COMMUNITY-BASED WAIVER SERVICES (HCBS).

~~Medicaid p~~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~~ under this rule. ~~(3-15-22)~~( )

01. Excluded Income. Income excluded under ~~the provisions of~~ IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," ~~Sections 723 and 725,~~ is excluded in determining participation. ~~(3-15-22)~~( )

02. Base Participation Amount. The ~~B~~base participation amount is income available ~~for participation~~ to the participant 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 Division of Welfare.~~ in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." ~~(3-15-22)~~( )

~~**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, "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.~~ ~~(3-15-22)~~

~~**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, "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.~~ ~~(3-15-22)~~

0~~5~~3. Personal Needs Allowance (PNA). The participant's ~~personal needs allowance~~ PNA depends on ~~whether~~ the participant's ~~has a~~ legal obligation to pay rent or mortgage. ~~The participant's personal needs allowance~~ and is deducted from ~~any~~ countable income after income exclusions and ~~before other allowable deductions~~ any incurred medical expenses allowances. ~~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
One hundred percent (100%) of the federal SSI benefit for a person with no spouse	One hundred and eighty percent (180%) of the Federal SSI benefit for a person with no spouse

(3-15-22)( )

a. PNA for participants not responsible for rent or mortgage equals one hundred percent (100%) of the federal SSI benefit. ( )

b. PNA for participants responsible for rent or mortgage equals one hundred eighty percent (180%) of the federal SSI benefit. ( )

064. Developmentally Disabled Participants with Developmental Disabilities. These allowances are specified in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." The HCBS personal needs allowance PNA 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 their own home. (3-15-22)( )

075. Incurred Medical Expenses. Amounts for certain limited medical or remedial services not covered by the participant's 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 verify such expenses for any to be considered for deduction. Costs for over-the-counter medications are included in the personal needs allowance PNA and will not be are not considered a medical expense. Department-approved Ddeductions for necessary medical or remedial expenses approved by the Department will be deducted at application, and changed, as necessary, based on changes reported are subtracted upon application, and updated when a participant reports changes to the Department by the participant. (3-15-22)( )

086. Remainder After Calculation. Any remainder after the calculation in Subsection 400.05 of this rule is the maximum participation amount to be deducted from the participant's provider payments to offset the cost of services. The participation amount will be is collected from the participant by the provider. The Department notifies the provider and the participant will be notified by the Department of the amount to be collected. (3-15-22)( )

097. Recalculation of Participation. The participant's participation amount must be is recalculated annually at eligibility redetermination or whenever a change in income or deductions becomes known to the Department upon verified changes. (3-15-22)( )

1008. 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 of overpayment or underpayment. (3-15-22)( )

401. -- 999. (RESERVED)

PROPOSED RULE COST/BENEFIT ANALYSIS

Section 67-5223(3), Idaho Code, requires the preparation of an economic impact statement for all proposed rules imposing or increasing fees or charges. This cost/benefit analysis, which must be filed with the proposed rule, must include the reasonably estimated costs to the agency to implement the rule and the reasonably estimated costs to be borne by citizens, or the private sector, or both.

Department or Agency: Department of Health and Welfare – Division of Medicaid

Agency Contact: Charles Beal **Phone:** (208) 364-1887

Date: June 2, 2023

IDAPA, Chapter and Title Number and Chapter Name:

16.03.18 – Medicaid Cost-Sharing

Fee Rule Status: X **Proposed** **Temporary**

Rulemaking Docket Number: 16-0318-2301

STATEMENT OF ECONOMIC IMPACT:

This rulemaking does not change any fee amounts in this chapter. In accordance with federal regulations at 42 CFR 447.57, the Department of Health and Welfare publishes a public schedule describing current Medicaid premiums and cost-sharing requirements on the **Idaho Medicaid Public Schedule of Premiums and Cost-Sharing** (https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=2085&dbid=0&repo=PUBLIC-DOCUMENTS&cr=1).