NOTICE OF INTENT TO SUBMIT STATE PLAN AND WAIVER AMENDMENTS AND SOLICITATION OF PUBLIC INPUT

Pursuant to 42 C.F.R. § 430.25 Waivers of State plan requirements, 42 C.F.R. § 440.345 EPSDT and other required benefits, 42 C.F.R. § 440.386 Public notice, 42 C.F.R. §441.304 Duration, extension, and amendment of a waiver, 42 C.F.R. § 447.203 Documentation of access to care and service payment rates, 42 C.F.R. § 447.204 Medicaid provider participation and public process to inform access to care, 42 C.F.R. § 447.205 Public notice of changes in Statewide methods and standards for setting payment rates, and 42 C.F.R. § 457.65 Effective date and duration of State plans and plan amendments, the Idaho Department of Health and Welfare Division of Medicaid (Department) provides public notice of its intent to submit a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS).

PROPOSED CHANGES

Idaho Medicaid intends to submit State Plan Amendments (SPAs) and Waiver Amendments to the Centers for Medicare and Medicaid Services (CMS) to reduce Idaho Medicaid rates by four percent (4%). This may include changes to the:

- Idaho Medicaid State Plan, particularly Attachment 4.
- 1915(b) Idaho Behavioral Health Plan Waiver, particularly Section D: Cost-Effectiveness.
- 1915(b) Idaho Medicaid Plus Waiver, particularly Section D: Cost-Effectiveness.
- 1915(b) Idaho Smiles Dental Services Waiver, particularly Section D: Cost-Effectiveness.
- 1915(c) HCBS Aged and Disabled (A&D) Waiver, particularly Appendix I: Financial Accountability.
- 1915(c) HCBS Developmental Disabilities (DD) Waiver, particularly Appendix I: Financial Accountability.
- 1915(i) HCBS State Plan Option Benefit for Adults with Developmental Disabilities (DD)
- 1915(i) HCBS State Plan Option Benefit for Children with Developmental Disabilities (DD)
- 1915(i) HCBS State Plan Option Benefit for Children with Serious Emotional Disturbance (SED)

On August 22, 2025, the Department issued information release MA25-17 Medicaid Provider Rate Adjustment. This notified providers that rates will be reduced by four percent (4%) across all provider types and services. These rates include, but are not limited to, hospitals (inpatient and outpatient); home and community-based services (HCBS); nursing facilities; hospice; school-based services; ambulatory surgical centers; intermediate care facilities; swing beds; some out-of-state facilities; and interim rates for federally qualified health centers. The information release linked to specific drafted fee schedules.

Capitation rates for managed care organizations will also be reduced by four percent (4%). Federal rules require changes to managed care rates to be actuarily sound. The department will work with managed care organizations to identify a corresponding reduction to their costs as required. This may be through provider rate reductions or changes to optional covered services.

Pharmacy reimbursement for claims being paid at Wholesale Acquisition Cost, State Maximum Allowable Cost, or the Federal Upper Limit as established by the Centers for Medicare and Medicaid Services (CMS) will decrease by four percent (4%). Professional dispensing fees will decrease by four percent (4%). Claims reimbursed at actual acquisition cost (AAC) will not be affected due to the nature of AAC being calculated from the invoice cost.

Provider Rates Not Impacted Due to Federal Requirements

Payments to tribal providers (Indian Health Services or other tribal facilities) will not be impacted by the four percent (4%) reduction as these providers are reimbursed entirely with federal funds when serving tribal members. Encounter rate payments to Federally Qualified Health Centers and Rural Health Centers will not be reduced by four percent (4%) due to federal requirements to reimburse at the established encounter rate. Interim rate changes for these provider groups will be reduced by four percent (4%) at this time.

The Department intends to submit these amendments to CMS with requested effective dates of September 1, 2025.

The Department attests that Medicaid payment rates in the aggregate (including base and supplemental payments) following the proposed reduction or restructuring for each benefit category affected by the proposed reduction or restructuring would be at or above eighty percent (80%) of the most recently published Medicare payment rates for the same or a comparable set of Medicare-covered services.

The Department attests that the proposed reduction or restructuring, including the cumulative effect of all reductions or restructurings taken throughout the current State fiscal year, would be likely to result in no more than a four percent (4%) reduction in aggregate fee-for-service Medicaid expenditures for each benefit category affected by proposed reduction or restructuring within a State fiscal year.

ESTIMATE OF EXPECTED CHANGE IN ANNUAL AGGREGATE EXPENDITURES

There is an expected decrease in annual aggregate expenditures.

PUBLIC REVIEW

When available, copies of the draft SPA and waiver pages will be posted on the IDHW website at https://healthandwelfare.idaho.gov/about-dhw/policies-procedures-and-waivers (under "Medicaid policies", PUBLIC-DOCUMENTS > About DHW > Policies & Standards > Medicaid > Draft State Plan Amendments).

Unless otherwise specified, copies are also available upon request for public review during regular business hours at any Regional Medicaid Services office of the Idaho Department of Health and Welfare.

LOCATIONS FOR PUBLIC REVIEW OF PROPOSED STATE PLAN AMENDMENT

Ada County
DHW Region 4, 1720 Westgate Drive, Boise, ID 83704
Central District Health Department, 707 North Armstrong Place, Boise, ID 83704

Adams County
Adams County Clerk's Office, 201 Industrial Avenue, Council, ID 83612

Bannock County
DHW Region 6, 1070 Hiline, Pocatello, ID 83201
Southeastern Idaho Public Health, 1901 Alvin Ricken Drive, Pocatello, ID 83201

Bear Lake County
Southeastern Idaho Public Health, 455 Washington, Suite #2, Montpelier, ID 83254

Benewah County
Panhandle Health District, 137 N 8th Street, St Maries, ID 83861

Bingham County
DHW Region 6, 701 East Alice, Blackfoot, ID 83221
Southeastern Idaho Public Health, 145 W Idaho Street, Blackfoot, ID 83221

Blaine County
South Central Public Health, 117 East Ash Street, Bellevue, ID 83313

Boise County
Boise County Clerk's Office, 420 Main Street, Idaho City, ID 83631

Bonner County
DHW Region 1, 207 Larkspur Street, Ponderay, ID 83852
Panhandle Health District, 2101 W. Pine Street, Sandpoint, ID 83864

Bonneville County
DHW Region 7, 150 Shoup Avenue, Idaho Falls, ID 83402
Eastern Idaho Public Health, 1250 Hollipark Drive, Idaho Falls, ID 83401

Boundary County
Panhandle Health District, 7402 Caribou Street, Bonners Ferry, ID 83805

Butte County
Southeastern Idaho Public Health, 178 Sunset Drive, Arco, ID 83213

Camas County
Camas County Clerk's Office, 501 Soldier Road, Fairfield, ID 83327

Canyon County
DHW Region 3, 3402 Franklin Road, Caldwell, ID 83605
Southwest District Health, 13307 Miami Lane, Caldwell, ID 83607

Caribou County
Southeastern Idaho Public Health, 55 East 1st South, Soda Springs, ID 83276

Cassia County
DHW Region 5, 2241 Overland Avenue, Burley, ID 83318

Clark County
Eastern Idaho Public Health, 332 West Main, Dubois, ID 83423

Clearwater County
North Central Health District, 105 115th Street, Orofino, ID 83544

Custer County
Eastern Idaho Public Health, 1050 N. Clinic Road, Suite A, Challis, ID 83226

Elmore County
DHW Region 4, 2420 American Legion Blvd., Mountain Home, ID 83647

Central District Health Department, 520 E. 8th Street N, Mountain Home, ID 83647

Franklin County
DHW Region 6, 223 North State, Preston, ID 83263
Southeastern Idaho Public Health, 50 West 1 St. South, Preston, ID 83263

Fremont County
Eastern Idaho Public Health, 45 South 2nd West, St. Anthony, ID 83445

Gem County
Southwest District Health, 1008 East Locust, Emmett, ID 83617

Gooding County
South Central Public Health, 255 North Canyon Drive, Gooding, ID 83330

Idaho County
DHW Region 2, Camas Resource Center, 216 South C Street, Grangeville, ID 83530
North Central Health District, 903 W Main, Grangeville, ID 83530

Jefferson County
Eastern Idaho Public Health, 380 Community Lane, Rigby, ID 83442

Jerome County
South Central Public Health, 951 East Avenue H, Jerome, ID 83338

Kootenai County
DHW Region 1, 1120 Ironwood Drive, Coeur d'Alene, ID 83814
Panhandle Health District, 8500 N. Atlas Road, Hayden, ID 83835

Latah County
DHW Region 2, 1350 Troy Highway, Moscow, ID 83843
North Central Health District, 333 E Palouse River Drive, Moscow, ID 83843

Lemhi County
DHW Region 7, 111 Lillian Street, Suite 104, Salmon, ID 83467
Eastern Idaho Public Health, 801 Monroe, Salmon, ID 83467

Lewis County
North Central Health District, 132 N Hill Street, Kamiah, ID 83536

Lincoln County
South Central Public Health, Lincoln County Community Center, 201 South Beverly St., Shoshone, ID 83352

Madison County
DHW Region 7, 333 Walker Drive, Rexburg, ID 83440
Eastern Idaho Public Health, 314 North 3rd East, Rexburg, ID 83440

Minidoka County

South Central Public Health, 485 22nd Street, Heyburn, ID 83336

Nez Perce County
DHW Region 2, 1118 F Street, Lewiston, ID 83501
North Central Health District, 215 10th Street, Lewiston, ID 83501

Oneida County
Southeastern Idaho Public Health, 175 South 300 East, Malad, ID 83252

Owyhee County
Southwest District Health, 132 E. Idaho, Homedale, ID 83628

Payette County
DHW Region 3, 515 N. 16th Street, Payette, ID 83661
Southwest District Health, 1155 Third Avenue North, Payette, ID 83661

Power County
Southeastern Idaho Public Health, 590 1/2 Gifford, American Falls, ID 83211

Shoshone County
DHW Region 1, 35 Wildcat Way, Suite B, Kellogg, ID 83837
Panhandle Health District, 114 Riverside Avenue W, Kellogg, ID 83837

Teton County
Eastern Idaho Public Health, 820 Valley Centre Drive, Driggs, ID 83422

Twin Falls County
DHW Region 5, 601 Pole Line Road, Twin Falls, ID 83301
South Central Public Health, 1020 Washington Street North, Twin Falls, ID 83301

Valley County
Central District Health Department, 703 1st Street, McCall, ID 83638

Washington County
Southwest District Health, 46 West Court, Weiser, ID 83672

PUBLIC COMMENT

The Department is accepting written and recorded comments regarding the proposed changes for a period of at least thirty (30) calendar days. Any persons wishing to provide input may submit comments.

Comments must be received by the Department within thirty (30) days of the posting of this notice, and must be sent using one of the following methods:

- *Send Email Comments To:* MCPT@dhw.idaho.gov
- *Call and Leave Recorded Comments At:* (208)-364-1887
- *Send Fax Comments To:* 1-208-287-1170
- *Mail Comments To:* Division of Medicaid
  PO Box 83720, Boise, ID 83720-0009
  Attn: Policy Team

Hand Deliver Comments During Regular Business Hours (M-F from 8AM to 5PM, except holidays) To:

Division of Medicaid
450 West State Street, 6th Floor, Boise, ID 83720
Attn: Policy Team

The Department will review all comments received prior to submitting the amendments to CMS.

PUBLIC HEARING

No public hearings have been scheduled at this time.

QUESTIONS

For technical questions or to review the changes, e-mail the request to MCPT@dhw.idaho.gov.

IDAHO DEPARTMENT OF HEALTH & WELFARE

BRAD LITTLE – Governor
ALEX J. ADAMS – Director

JULIET CHARRON – Deputy Director
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

August 28, 2025

Dear Tribal Representative:

In accordance with section 1902(a)(73)(A) of the Social Security Act regarding the solicitation of advice prior to the submission of any Medicaid or CHIP State Plan Amendment (SPA) or waiver application or amendment likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations, the Idaho Department of Health and Welfare (IDHW) Division of Medicaid (Idaho Medicaid) provides notice on the following matter.

Purpose

Idaho Medicaid intends to submit State Plan Amendments (SPAs) and Waiver Amendments to the Centers for Medicare and Medicaid Services (CMS) to reduce Idaho Medicaid rates by four percent (4%). This may include changes to the:

- Idaho Medicaid State Plan, particularly Attachment 4.
- 1915(b) Idaho Behavioral Health Plan Waiver, particularly Section D: Cost-Effectiveness.
- 1915(b) Idaho Medicaid Plus Waiver, particularly Section D: Cost-Effectiveness.
- 1915(b) Idaho Smiles Dental Services Waiver, particularly Section D: Cost-Effectiveness.
- 1915(c) HCBS Aged and Disabled (A&D) Waiver, particularly Appendix I: Financial Accountability.
- 1915(c) HCBS Developmental Disabilities (DD) Waiver, particularly Appendix I: Financial Accountability.
- 1915(i) HCBS State Plan Option Benefit for Adults with Developmental Disabilities (DD)
- 1915(i) HCBS State Plan Option Benefit for Children with Developmental Disabilities (DD)
- 1915(i) HCBS State Plan Option Benefit for Children with Serious Emotional Disturbance (SED)

On August 22, 2025, the Department issued information release MA25-17 Medicaid Provider Rate Adjustment. This notified providers that rates will be reduced by four percent (4%) across all provider types and services.

Payments to tribal providers (Indian Health Services or other tribal facilities) will not be impacted by the four percent (4%) reduction as these providers are reimbursed entirely with federal funds when serving tribal members. Encounter rate payments to Federally Qualified Health Centers and Rural Health Centers will not be reduced by four percent (4%) due to

federal requirements to reimburse at the established encounter rate. Interim rate changes for these provider groups will be reduced by four percent (4%) at this time.

These changes are in compliance with *42 C.F.R. § 430.25 Waivers of State plan requirements; 42 C.F.R. § 440.345 EPSDT and other required benefits; 42 C.F.R. § 440.386 Public notice; 42 C.F.R. §441.304 Duration, extension, and amendment of a waiver; 42 C.F.R. § 447.203 Documentation of access to care and service payment rates; 42 C.F.R. § 447.204 Medicaid provider participation and public process to inform access to care; 42 C.F.R. § 447.205 Public notice of changes in Statewide methods and standards for setting payment rates; and 42 C.F.R. § 457.65 Effective date and duration of State plans and plan amendments.*

Proposed Effective Date

The Department intends to submit these amendments to CMS with requested effective dates of September 1, 2025.

Anticipated Impact on Indians/Indian Health Program/Urban Indian Organizations

A. Does this change directly affect American Indians / Alaska Natives (AI/AN) or Indian Health Care Providers (IHCPs) but is federally or statutorily mandated?

These changes are driven by state executive orders.

B. Does the change impact services or access to services provided, or contracted for, by Indian Health Care Providers (IHCPs) including but not limited to:

- *Decrease/increase in services*
- *Change in provider qualifications/requirements*
- *Change service eligibility requirements (i.e. prior authorization)*
- *Place compliance costs on Indian Health Care Providers (IHCPs)*
- *Change in reimbursement rate or methodology*

The proposed changes do not change available services under IHCPs. They do not change provider qualifications/requirements. They do not change service eligibility requirements (i.e. prior authorizations). They do not place compliance costs on IHCPs. They do change reimbursement rates and methodology for IHCPs.

C. Does the change negatively impact or change the eligibility for, or access to, American Indians / Alaska Natives (AI/AN) Medicaid?

The proposed changes do not impact Medicaid eligibility or enrollment of American Indians / Alaska Natives (AI/AN).

Availability for Review

When available, copies of the draft SPA pages will be posted on the IDHW website at https://healthandwelfare.idaho.gov/about-dhw/policies-procedures-and-waivers (under "Medicaid policies", PUBLIC-DOCUMENTS > About DHW > Policies & Standards > Medicaid > Draft State Plan Amendments).

Comments, Input, and Tribal Concerns

Idaho Medicaid appreciates any input or concerns that Tribal representatives wish to share regarding these changes. Please submit any comments prior to **September 28, 2025,** by email addressed to MCPT@dhw.idaho.gov. These proposed SPA will also be reviewed as part of the Policy Update at the next Quarterly Tribal meeting.

Sincerely,

Juliet Charron
Administrator

JC

Idaho Medicaid State Plan, particularly Attachment 4

F. Payment to a Medicaid provider shall be:

I. Where there is an equivalent the payment to a Medicaid provider for primary care procedure codes, as defined by the Centers for Medicare and Medicaid Services, payment will not exceed ~~one hundred percent (100%)~~ninety-six percent (96%) of the Medicare rate; and payment will be ~~ninety percent (90%)~~eighty-six percent (86%) of the Medicare rate for all other procedure codes.

1. Where there is no Medicare equivalent, payment will be prescribed by use of approved pricing documentation, which may include but is not limited to invoices that list the manufacturer's suggested retail pricing (MSRP), Average Wholesale Price (AWP), and/or Wholesale Acquisition Cost (WAC). This will be reduced by four percent (4%).

2. The fee schedule for these services is published at:

http://www.healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers, effective for the dates noted on the published version.

G. The Medicaid payment for primary care case management under Idaho's Primary Care Case Management (PCCM) program is paid in addition to fee-for-service (FFS) to physicians and non-physician practitioners who are enrolled as providers in the PCCM program. The structure is based on the primary care provider's ability to meet those needs. The case management fee is:

I. **TIER 1 – HEALTHY CONNECTIONS**.

1. Three dollars ($3.00) per member per month (PMPM) for all individuals enrolled in the Healthy Connections Tier with the PCCM provider.

II. **TIER 2 – HEALTHY CONNECTIONS CARE MANAGEMENT.**

1. Seven dollars ($7.00) PMPM for all individuals enrolled in the Healthy Connections Care Management Tier with the PCCM provider.

III. **TIER 3 – HEALTHY CONNECTIONS MEDICAL HOME.**

1. Nine dollars fifty cents ($9.50) PMPM for all individuals enrolled in the Healthy Connections Medical Home Tier with the PCCM provider.

1915(i) HCBS State Plan Option Benefit for Children with Serious Emotional Disturbance (SED)

Methods and Standards for Establishing Payment Rates

(a) Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☒	HCBS Respite Care The payment rate for this service is set by a managed care contractor.
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☐	Other Services (specify below)

1915(i) HCBS State Plan Option Benefit for Children with Developmental Disabilities (DD)

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☑	HCBS Habilitation (Community-Based Supports)
	Individual and Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Community-Based Supports Individual and Group, we use the (BLS) mean wage (Idaho) for all others (BLS code 31-1011) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .5% and SFY 2011 it is .8%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report. The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 85.5% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 85.5% adjusted target rate. This figure will be reduced by four percent (4%).
☑	HCBS Respite Care
	Individual and Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Respite Individual and Group, we use the Bureau of Labor statistics (BLS) mean wage (Idaho) for all others (BLS code 39-9099) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using Global Insights Mountain States Market Basket (GI) inflation index. In SFY 2010 (2 months) it was .5% and SFY 2011 it is .8%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS Mountain West Division's (MWD) report. The dollar figure arriving from the calculations is divided by the artio provided. The hourly rate

	then is brought into a quarterly unit rate, or the target rate. The final unit rate for Respite Individual is 77% of the target rate. The final unit rate for Respite group is 100% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 77% and the 100% respectfully for the adjusted target rate. This figure will be reduced by four percent (4%).	
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (specify below)	
	☑	Family Education:
	The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for Family Education Individual and Group, we use the (BLS) mean wage (Idaho) for all others (BLS code 29-1129) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (01) index. In SFY 2010 (2 months) it was .5% and SFY 2011 it is .8%, Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWO) report. The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 76.6% of the target rate. We are using the most current OO/MH rates dictated by Idaho code 56-118 and used to calculate the 76.6% adjusted target rate. This figure will be reduced by four percent (4%).	
	☑	Home Modification:
	For adaptations over $500, three bids are required if it is possible to obtain three bids. The lowest bid which meets the participant's needs is selected.	
	☑	Service Dog:
	For service animals costing over $2,000.00, three bids are required if it is possible to obtain three bids. The lowest bid which meets the participant's needs is selected. For training, annual healthcare, and ongoing maintenance of the animal costing over $500.00, three bids are required if it is possible to obtain three bids. The lowest bid which meets the participant's need is selected	
	☑	Adaptive and Therapeutic Equipment:
	For equipment and supplies that are manually priced, including miscellaneous codes, a copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer is required. Reimbursement will be seventy-five percent (75%) of MSRP. If pricing documentation is the invoice, reimbursement will be at cost plus ten percent (10%), plus shipping (if that documentation is provided). For equipment and supplies that are not manually priced, the rate is based on the Medicaid fee schedule price.	

☑	Supports for Participant Direction (specify below)	
	☑	Family-Directed Personal Support:
	The participant and parent/legal guardian negotiates the rate with community support staff, ensuring the rates negotiated do not exceed the prevailing market rate.	
	☑	Family-Directed Goods and Services:
	The participant and parent/legal guardian negotiates the rate with community support staff, ensuring the rates negotiated do not exceed the prevailing market rate.	
	☑	Family-Directed Non-Medical Transportation:
	The participant and parent/legal guardian negotiates the rate with community support staff, ensuring the rates negotiated do not exceed the prevailing market rate.	
	☑	Financial Management Services:
	Financial Management Services -Reimbursement methodology for FMS is based on a market study of other state Medicaid program rates for FMS to gather a range which allows the Department to accept a Per Member Per Month (PMPM) rate within the range determined from the market study. The established PMPM payment rates for each department approved qualified FMS provider will be published on a fee schedule by the Department. This fee schedule will be updated at least yearly, and when new providers are approved. This information will be published for consumer convenience to the IDHW Medicaid website, and by request.	
	☑	Support Broker Services:
	The participant and parent/legal guardian negotiates the rate with the support broker, ensuring the negotiated rate does not exceed the maximum hourly rate for support broker services established by the Department.	

1915(i) HCBS State Plan Option Benefit for Adults with Developmental Disabilities (DD)

Methods and Standards for Establishing Payment Rates

9. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

[X] HCBS Habilitation

For health professionals authorized to administer developmental disability services, the statewide reimbursement rate for developmental disability services was derived by using Bureau of Labor Statistics mean wage for the direct care staff. This rate was then adjusted for employment related expenditures and indirect general and administrative costs (which includes program related costs and are based on surveyed data).

Reimbursement rates for these services are set at a percentage of the statewide target reimbursement rate described above.

The following CPT codes represent the service codes paid for Developmental Therapy and Community Crisis Supports.

Code	Description	Rate of Reimbursement
97537	Development Therapy in Home or Community (per 15 minute)	$ 6.01
H2032	Development Therapy in Center (per 15 minute)	$ 4.00
H2011	Community Crisis Support (per 15 minute)	$10.90
H2000	Developmental Therapy Evaluation (per 15 minute)	$16.27

1915(b) Idaho Behavioral Health Plan Waiver, particularly Section D: Cost-Effectiveness

3. Explain any differences:

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (5 of 5)

p. ***Other adjustments*** including but not limited to federal government changes.

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the States FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
- - Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)** *: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

  Basis and Method:

  1. ☐ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population **which includes accounting for Part D dual eligibles**. Please account for this adjustment in **Appendix D5.**
  2. ☐ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractors providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles**.
  3. ☐ Other

     Please describe:

1. ☐ No adjustment was made.

2. ☒ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5. Please describe

Total capitation payment is reduced by four percent (4%).

Section D: Cost-Effectiveness

Part I: State Completion Section

K. Appendix D5 Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in Section D.I.I and D.I.J above.

See attached spreadsheet

Appendix D5 Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

L. Appendix D6 RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in Section D.I.E. above.

See attached spreadsheet

Appendix D6 RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

2. Please explain unit cost changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of cost increase given in Section D.I.I and D.I.J:

3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of utilization given in Section D.I.I and D.I.J:

b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.

Appendix D7 - Summary

1915(b) Idaho Smiles Dental Services Waiver, particularly Section D: Cost-Effectiveness

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (5 of 5)

p. ***Other adjustments*** including but not limited to federal government changes.

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the States FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
- - Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)** *: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

  Basis and Method:

  1. ☐ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population **which includes accounting for Part D dual eligibles**. Please account for this adjustment in **Appendix D5.**
  2. ☐ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractors providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles**.
  3. ☐ Other

     Please describe:

1. ☐ No adjustment was made.

2. ✕ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5. Please describe

Total capitation payment is reduced by four percent (4%).

Section D: Cost-Effectiveness

Part I: State Completion Section

K. Appendix D5 Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in Section D.I.I and D.I.J above.

Appendix D5 Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

L. Appendix D6 RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in Section D.I.E. above.

Appendix D6 RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

2. Please explain unit cost changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of cost increase given in Section D.I.I and D.I.J:

3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of utilization given in Section D.I.I and D.I.J:

b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.

Appendix D7 - Summary

1915(b) Idaho Medicaid Plus Waiver, particularly Section D: Cost-Effectiveness

The actual documented trend is:

Please provide documentation.

2. ☐ [Required, when the States BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the lower of State historical 1915(b)(3) trend or States trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. A. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years
2. Please provide documentation.

B. State Plan Service trend

Please indicate the State Plan Service trend rate from Section D.I.J.a. above

e. Incentives (not in capitated payment) Trend Adjustment: If the State marked **Section D.I.H.d ,** then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from Section D.I.I.a
2. List the Incentive trend rate by MEG if different from Section D.I.I.a
3. Explain any differences:

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (5 of 5)

p. *Other adjustments* including but not limited to federal government changes.

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the States FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
- Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount

and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.

- For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)** *: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1. ☐ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population **which includes accounting for Part D dual eligibles**. Please account for this adjustment in **Appendix D5.**
2. ☐ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractors providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles**.
3. ☐ Other

Please describe:

1. ☐ No adjustment was made.

2. ✕ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5. Please describe

Total capitation payment is reduced by four percent (4%).

Section D: Cost-Effectiveness

Part I: State Completion Section

K. Appendix D5 Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in Section D.I.I and D.I.J above.

The State adjusted the dates of historical cost increase data used to base rates from 2015-2017 to 2021-2022.

Appendix D5 Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

L. Appendix D6 RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in Section D.I.E. above.

Projections for this waiver amendment included only the counties where the mandatory Idaho Medicaid Plus program is expanding to operate in 2025.

Initial decrease in eligible participants due to end of the COVID-19 Public Health Emergency on 4/1/2023 causing an end to continuous Medicaid enrollment. Additional increases in trends are due to Idaho continuing to experience record population growth resulting in an increase of eligible participants in each of the counties in operation.

Appendix D6 RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

Variances in overall percentage change in spending are due to the State projections for the initial application included the populations for all counties in Idaho, whether they were active or not.

Original projections included only counties with mandatory enrollment in the Idaho Medicaid Plus program as of the last waiver renewal. Projections were amended due to expansion of mandatory enrollment into additional counties submitted to CMS with waiver amendment ID.0004.R01.01. Additional variances are due to an initial slight decrease in eligible participants due to end of the COVID-19 Public Health Emergency on 4/1/2023 causing an end to continuous Medicaid enrollment and continuing unprecedented population growth across all populations in Idaho.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

Initial decrease in eligible participants due to end of the COVID-19 Public Health Emergency on 4/1/2023 causing an end to continuous Medicaid enrollment. Overall enrollment expected to continue to increase in eligible participants due to geographic expansion as well as continued unprecedented growth of Idaho’s population.

2. Please explain unit cost changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of cost increase given in Section D.I.I and D.I.J:

State historical FFS cost increases using SFYs 2019-2020 for trend of 2.4% determined by linear regression.

3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of utilization given in Section D.I.I and D.I.J:

Changes in utilization of the waiver are due to an initial decrease in eligible participants due to end of the COVID-19 Public Health Emergency on 4/1/2023 causing an end to continuous Medicaid enrollment and Idaho continuing to experience record population growth resulting in an increase of eligible participants in each of the counties in operation.

b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.

The adjustments applied for State Plan Programmatic changes (risk adjustment for case mix due to one MEG used for duals) and the Quality Improvement costs (Administration Costs - Improvement) contribute to the overall annualized rate of change.

Appendix D7 - Summary

1915(c) HCBS Developmental Disabilities (DD) Waiver, particularly Appendix I: Financial Accountability

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

○ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Department provides public notice of significant reimbursement changes in accordance with 42 CFR § 447.205 (made applicable to waivers through 42 CFR § 441.304(e)). Pursuant to 42 CFR §447.205, the State publishes public notice of proposed reimbursement changes in multiple newspapers throughout the State and on the Department's website at www.healthandwelfare.idaho.gov. Copies of public notices and text of proposed significant reimbursement changes are made available for public review on Department's website and during regular business hours at agency locations in each Idaho county as identified in each public notice. Additionally, payment rates are published on the Department's website at for the public to access.

The Adult Developmental Disabilities Waiver Services fee schedule is found in the Provider Resources folder under > Medicaid > Fee Schedules > Provider Reimbursement Rates folder located at: https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=3488&dbid=0&repo=PUBLIC-DOCUMENTS. Select the link for year desired to view waiver provider rates by that year.

The Department provides opportunity for meaningful public input related to proposed reimbursement changes in accordance with 42 CFR § 441.304(f). The Department solicits comments from the public (including beneficiaries, providers and other stakeholders) through its public notice process and through public hearings related to the proposed reimbursement changes. The public is given the opportunity to comment on the proposed reimbursement changes for at least thirty (30) days prior to the submission of any waiver amendment to CMS. Additionally, when Administrative Rules are promulgated in connection with reimbursement changes, the proposed rules are published in the Idaho Administrative Bulletin and the public is given at least twenty-one (21) days after the date of publishing to comment.

Waiver service providers will be paid on a fee for service basis as established by the Department depending on the type of service provided. The state collaborates with providers on rate reviews for the services outlined below through direct outreach via email or phone, meetings and Information Releases. Oversight of the rate determination process is conducted by a third-party accounting firm, a provider workgroup, legislative joint finance committee and state Medicaid staff. The Bureau of Financial Operations is responsible for rate determinations. Main Section 6-I describes the state's process for soliciting public comments on rate determination methods.

Review and rebasing reimbursement rates are initiated through cost surveys and/or when an access or quality indicator reflects a potential issue as outlined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" Sections 037-038. Rebasing is finalized through the approval of Idaho budget requests as authorized by the Idaho State Legislature. Providers and participants with questions about pricing should contact Medicaid's Office of Reimbursement by phone (208) 287-1180 or email MedicaidReimTeam@dhw.idaho.gov.

Service Rate Methodology Information:
A. General Rate Provisions.
1. The state reimburses services at the same rate statewide, and
2. Rates may vary by provider type under this waiver. Differences are indicated by provider type on the published Adult Developmental Disabilities Waiver Services Fee Schedule.
Differences are driven by provider-specific cost surveys that review wage and cost data collected from providers directly, the Bureau of Labor Statistics, and the Internal
Revenue Service.
B. Fee-For-Service Rates.
1. Rates Developed by the Cost Survey Model.
a. Adult Day Health. Rates were last reviewed and rebased SFY 2022.
b. Residential Habilitation. Rates were last reviewed SFY 2022 and last rebased SFY 2018. Rates for Residential Habilitation vary by level of Supported Living and/or Certified
Family Home (CFH) service provided, but do not vary by provider type.
c. Supported Employment Services. Rates were last reviewed and rebased SFY 2020.
d. Behavioral Consultation/Crisis Management. Rates were last reviewed SFY 2020 and rebased SFY 2008. Rates vary by provider qualifications as indicated on the published fee
schedule.
e. Respite Care. Rates were last reviewed and rebased SFY 2022. Rates vary by provider type as indicated on the published fee schedule.

2. Manually Priced Rates.
a. Chore Services. Items are manually priced based on the submitted invoice price.

b. Environmental Accessibility Adaptations. for adaptations over $500, three (3) bids are required if it is possible to obtain three (3) bids. The lowest bid which meets the participant's needs is selected.

c. Specialized Medical Equipment and Supplies. For equipment and supplies that are manually priced, including miscellaneous codes, a copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer is required. Reimbursement is seventy-five percent (75%) of MSRP. If pricing documentation is the invoice, reimbursement is at cost plus ten percent (10%), plus shipping (if that documentation is provided). For equipment and supplies that are not manually priced, the rate is based on the published Medicaid fee schedule price.

d. Transition Services. Service is manually priced; projected amount for this benefit is calculated based on an average of actual expenses for this service over the previous waiver cycle (for this renewal, actual expenses were averaged for waiver years 2 through 5 (FFY2019 through FFY2022) of the previous waiver cycle as Transition Services was not added to this waiver until FFY 2019).

3. Other Rate Models.

a. Home Delivered Meals. The initial rate was set in 1999 based on time studies in nursing facilities. Rates related to Home Delivered Meals were last reviewed SFY 2020 and rebased SFY 2011.

b. Non-Medical Transportation (NMT). A study was conducted evaluating the actual costs of fuel reasonably incurred by the typical non-commercial transportation provider whose personal vehicle averages fifteen (15) miles per gallon. Rates vary by provider type and service offered as indicated on the published fee schedule. Rates were last reviewed and rebased SFY 2010.

c. Personal Emergency Response System (PERS). The rate was developed by surveying PERS vendors in all seven (7) regions of the State to calculate a state-wide average. The state-wide average is the rate paid for this service. Rates were last reviewed and rebased SFY 2011.

d. Skilled Nursing. These services are paid on a uniform reimbursement rate based on an annual survey conducted by the Department. Rates were last reviewed SFY 2022 and rebased SFY 2014. Rates vary by provider type and license of direct care staff as indicated on the published fee schedule.

3. Self-Direction Rates.

a. Non-Medical Transportation, Skilled Nursing Services, Specialized Medical Equipment and Supplies, Support Broker Services, and Community Support Services. Rates are set by the participant based on the specific needs of the participant through negotiation with the Department. The identified rates may not exceed prevailing market rates, identified using Bureau of Labor and Statistics wage data. The Department provides training and resource materials to assist the participant, Support Broker, and circle of supports to make this determination. The participant and their Support Broker monitor this requirement each time the participant enters into an employment agreement. The Department ensures that the proposed plan of service does not exceed the overall budget at the time of plan review and approval. The Department also reviews a statistically valid sample of participant employment agreements during the annual retrospective quality assurance reviews.

b. Financial Management Services (FMS). Reimbursement methodology for FMS is based on a market study of other state Medicaid program rates for FMS to gather a range which allows the Department to accept a Per Member Per Month (PMPM) rate within the range determined from the market study. The established PMPM payment rates for each Department approved qualified FMS provider is published on a fee schedule by the Department. This fee schedule is updated at least yearly, and when new providers are approved. This information is published for consumer convenience the Department's website.

c. Transition Services. Rates are set by the participant based on the specific needs of the participant through negotiation with the Department. Expenses for Transition Services may not exceed $2,000 per qualifying transition.

All rates will be reduced by four percent (4%).

1915(c) HCBS Aged and Disabled (A&D) Waiver, particularly Appendix I: Financial Accountability

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ***No***
- ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

A. Rate Update Process. The State provides public notice of significant rate changes in accordance with 42 CFR § 447.205 and 42 CFR § 441.304(e). The State publishes public notice of proposed changes in multiple newspapers throughout the state and on the Department's website. Copies of public notices and text of proposed significant rate changes are made available for public review on the Department's website and during regular business hours at agency locations in each Idaho county as identified in the public notice. Additionally, payment rates are published on the Department's website for participants, the public, and providers to access. Current Aged & Disabled (A&D) Waiver Services fee schedules are found in the Provider Resources folder under > Medicaid > Fee Schedules > Provider Reimbursement Rates > HCBS and LTSS folder located at https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=25868&dbid=0&repo=PUBLIC-DOCUMENTS. Select the appropriate link for specific provider type desired to view current rates.

The State provides opportunity for meaningful public input related to proposed rate changes in accordance with 42 CFR § 441.304(f). The State solicits comments from the public (beneficiaries, providers, and other stakeholders) through its public notice process and through public hearings related to the proposed rate changes. The public is given the opportunity to comment for at least thirty (30) days prior to the submission of any waiver amendment to the Centers for Medicare and Medicaid Services (CMS). Additionally, the State solicits comments at public hearings when Administrative Rules are promulgated in connection with rate changes, proposed rules are published in the Idaho Administrative Bulletin and the public has the opportunity to comment on proposed rules for at least twenty-one (21) days after the publish date.

Waiver providers are paid on a fee-for-service (FFS) basis as established by the State and the type of service provided. The State collaborates with providers on rate reviews for the services outlined below through direct outreach via email or phone, meetings, and Information Releases. Rate determination process is reviewed by a third-party accounting firm, provider workgroups, legislative joint finance committee and Medicaid staff. The Bureau of Financial Operations (BFO) is responsible for rate determinations. The State ensures that Managed Care Entities (MCE) reimburse providers at a rate no less than the current Medicaid Provider rates. Main Section 6-I describes the process for soliciting public comments on rate determination methods.

Review and rebasing rates are initiated through cost surveys every 5 (five) years, the provider rate review process, the weighted average hourly wage survey, and/or when an access or quality indicator reflects a potential issue as outlined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" Section 037. Rebasing is finalized through the approval of budget requests as authorized by the Idaho State Legislature. Contact Medicaid's Office of Reimbursement for questions by phone (208) 287-1180 or email MedicaidRateReview@dhw.idaho.gov.

B. Service Rate Methodology.
1. General Rate Provisions:
a. The State pays the same rates for services provided under the self-directed model using a Fiscal Intermediary (FI) Agency as it pays for rates provided by a Personal Assistance Agency (PAA).
b. The State reimburses services at the same rate statewide.
c. Service rates may vary by provider type under this waiver. Differences are indicated by provider type on the published Fee Schedules and as described below. Differences are driven by provider-specific cost surveys reviewing wage and cost data collected from providers throughout the state directly, the Bureau of Labor Statistics, and the Internal Revenue Service.

2. FFS Rates:
a. Adult Day Health (ADH). The initial rate was set in 1999 based on time studies in nursing facilities. Rates in Waiver Year 1 of the Workbook include enhanced payments for all provider types ($2.79 per 15-minute unit) authorized under an approved Emergency Appendix K Amendment related to the Coronavirus Public Health Emergency (PHE). When the PHE rate increases expire, ADH services provided by Developmental Disability Agencies (DDA) will continue to be paid at $2.79 per 15-min. unit. All other provider types will return to the $1.50 per 15-min. unit rate. Rates related to ADH were last reviewed and rebased SFY 2022.
b. Home Delivered Meals. The initial rate was set in 1999 based on time studies in nursing facilities. Rates were last reviewed SFY 2020 and rebased SFY 2011.
c. Residential Habilitation (ResHab) and Supported Employment. The rate model used to develop these rates is described in Idaho Code 16.03.10, "Medicaid Enhanced Plan Benefits," Section 038.04, "Reimbursement Rate Setting Methodology." ResHab rates were last reviewed SFY 2022 and last rebased SFY 2018. Supported Employment rates were last reviewed and rebased SFY 2020.

d. Consultation Services, Personal Emergency Response System (PERS), and Day Habilitation. The initial rates were set back in 1999 based on time studies in nursing facilities. Ongoing rates are set based on a labor model using a Staff Support Hour (SSH) rate approach, which involves developing a single rate for a unit of staff time spent providing services for a participant. Rates related to these services were last reviewed and rebased SFY 2011.
e. Attendant Care, Homemaker Services, Companion Services, Chore Services, and Respite Care. The rate model used to develop rates for these services is described in Idaho Code (IDAPA) 16.03.10, "Medicaid Enhanced Plan Benefits". These services are identified as Personal Care Services (PCS) where methodology is described in Section 307, "Personal Care Services: Provider Reimbursement," under Subsections .01 through .04. In addition, Section .037 "General Reimbursement: Participant Services," Subsection 02 requires the state to conduct a cost survey when there are identified access issues. The current hourly rate calculation was determined when the state followed Idaho Code 16.03.10.307.04.a in calculating a direct care wage. This section says the state will establish Personal Assistance Agency (PAA) rates for personal assistance services based on the Weighted Average Hour Rate (WAHR). The state then followed Idaho Code 16.03.10.307.04.b in calculating a supplemental component. This section says the state will calculate a supplemental component using costs reported for travel, administration, training, payroll taxes and fringe benefits (employment related expenditures, program related costs, and indirect general and administrative costs). Rates for these services were last reviewed and rebased SFY 2022.
• Respite provided by a PAA is paid at $4.99 per 15-min. unit, while the rate for Respite provided by an Adult Residential Care provider is $2.64 per 15-min. unit.
f. Adult Residential Care. Services are paid per diem based on the number of hours and types of assistance required by each individual participant as identified in the Uniform Assessment Instrument (UAI). Individual component rates for services that factor into these per diem rates (Attendant Care and Homemaker) were last reviewed and rebased SFY 2022.
g. Non-Medical Transportation (NMT). A study is conducted that evaluates the actual costs of fuel reasonably incurred by the typical non-commercial transportation provider whose personal vehicle averages fifteen (15) miles per gallon. Agency providers are paid $0.44 per mile. Commercial providers are paid $4.20 for the first mile of their first trip in the day, plus $1.17 per mile. Commercial Bus passes are manually priced. NMT rates were last reviewed and rebased SFY 2010.
h. Specialized Medical Equipment & Supplies. Service items are manually priced (including miscellaneous codes), require a copy of the manufacturer's suggested retail pricing (MSRP), an invoice, and/or quote from the manufacturer. Reimbursement is for seventy-five percent (75%) of MSRP. When pricing documentation includes the invoice, reimbursement is at cost plus ten percent (10%), plus shipping (when documentation is provided). For codes that are not manually priced, the rate is based on the currently posted Medicaid fee schedule price.
i. Environmental Accessibility Adaptations. Service is manually priced; for adaptations over $500, three (3) bids are required whenever possible. The lowest bid which meets the participant's needs is selected.
j. Skilled Nursing. Services are paid on a uniform reimbursement rate based on an annual survey conducted by the Department. Individual services provided by direct care nursing staff are reimbursed by license and/or service. Registered Nurses (RN) are reimbursed at $10.19 per 15-min. unit, Licensed Practical Nurses (LPN) are reimbursed at $7.31 per 15-min. unit, and Nursing oversight activities are paid at $50.95 per visit. Rates were last reviewed SFY 2022 and rebased SFY 2014.
k. Transition Services. Service is manually priced; projected usage amount for this benefit is calculated based on an average of actual expenses for this service over the previous waiver cycle starting FFY 2019 when Transition Services were added to the waiver.

2. MCE Rates.
a. The Contracts between the State and the MCEs shall be a firm fixed fee, indefinite quantity contract for services specified in the Scope of Work. For payment purposes, a capitated payment is calculated based on the current eligible Medicare Medicaid Coordinated Plan (MMCP) or Idaho Medicaid Plus participant count multiplied by the Per Member Per Month (PMPM) figure and is intended to adequately to support participant access to, and utilization of covered services, including administrative costs. The total PMPM payment is comprised of two (2) components; the medical capitation and the blended Long Term Services and Supports (LTSS) costs. Once the eligible Enrollee count by enrollment status is determined for the contract, the blended LTSS rate will remain in effect through the contract period.
b. Initial projections used for population distribution between the MMCP, Idaho Medicaid Plus, and Fee-For-Service mix was derived using the following assumptions as we did not have sufficient enrollment data to project how the Dual Population would distribute out in the mix:
i. Counties with Mandatory Enrollment, the State assumed that Idaho Medicaid Plus would have the largest group, with MMCP second largest and FFS smallest. Estimated a 50-40-10 distribution.
ii. Counties with Voluntary Enrollment, the State assumed that largest group would be comprised of MMCP, with some

FFS and no Idaho Medicaid Plus. Estimated a 25-75-0 distribution.
iii. Counties with Passive Enrollment, the State assumed that Idaho Medicaid Plus would have the largest group, with MMCP second largest and FFS smallest. Estimated a 60-25-15 distribution.
c. For this waiver renewal, the State had sufficient enrollment data over the last waiver cycle (SFY2018-2021) to predict with reasonable confidence that the population mix is much more even than expected.

Amendment R07.01 Effective 4/1/2024:
1. Skilled Nursing rates were reviewed in SFY 2023. The following services were reviewed and rebased in SFY 2023: ADH, Adult Residential Care - Certified Family Home (CFH), Attendant Care, Chore, Companion, Home Delivered Meals, Homemaker, PERS, ResHab, Respite, and Supported Employment,
2. ADH rates related to the PHE expired November 2023. DDA rates remain at $2.79 per 15-min. unit and rates for ADH provided by CFHs now pay at $1.95 per 15-min. unit as approved in the 2023 Idaho Legislature. All other ADH providers returned to the $1.50 per 15-min. unit rate effective November 12, 2023.
3. Attendant Care is reimbursed at the same rate whether a spouse caregiver is used or not.

All rates are reduced by four percent (4%).

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