NOTICE OF INTENT TO SUBMIT STATE PLAN OR WAIVER AMENDMENT 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 a SPA to adjust the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) reimbursement process for change-of-scope.

S1410 MEDICAID (2026) added Idaho Code § 56-2208 Legislative Approval -- Change In Encounter Rate Due To Change In Scope Of Services. It also voids IDAPA 16.03.26.307 FQHC And RHC: Rate Setting Methodology on October 1, 2026. The new state code adjusts the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) reimbursement process for change-of-scope.

The Department intends to submit this amendment to CMS with a requested effective date of October 1, 2026.

ESTIMATE OF EXPECTED CHANGE IN ANNUAL AGGREGATE EXPENDITURES

There is no expected increase or decrease in annual aggregate expenditures.

PUBLIC REVIEW

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

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 and should be aware that personally identifiable information (PII) may be subject to public disclosure. Commentors should refrain from submitting Protected Health Information (PHI).

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 as part of the submission 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
JULIET CHARRON – Director

SASHA O'CONNELL—Deputy Director
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-5500
FAX 208-334-6558

September 24, 2026

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 a SPA to adjust the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) reimbursement process for change-of-scope.

S1410 MEDICAID (2026) added *Idaho Code § 56-2208 Legislative Approval -- Change In Encounter Rate Due To Change In Scope Of Services*. It also voids *IDAPA 16.03.26.307 FQHC And RHC: Rate Setting Methodology* on October 1, 2026. The new state code adjusts the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) reimbursement process for change-of-scope.

These changes are in compliance with *42 C.F.R. § 440.345 EPSDT and other required benefits, 42 C.F.R. § 440.386 Public notice, 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 the SPA to CMS with a requested effective date of October 1, 2026.

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?

The proposed changes are statutorily mandated.

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*

There is no impact to services provided, or contracted for, by Indian Health Care Providers (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 negatively impact or change eligibility for, or access to AI/AN Medicaid.

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/rules-policies-procedures-and-waivers under "Medicaid policies" (PUBLIC-DOCUMENTS > About DHW > Policies & Standards > Medicaid > Medicaid Public Notices).

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 **October 30, 2026,** email addressed to MCPT@dhw.idaho.gov or to the Idaho Medicaid Tribal Liaison mahailla.emele@dhw.idaho.gov. These proposed changes will also be reviewed as part of the Policy Update at the next Quarterly Tribal meeting.

Sincerely,

Sasha O'Connell
Deputy Director

SO/as

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
JULIET CHARRON – Director

SASHA O'CONNELL—DEPUTY DIRECTOR
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-5500
FAX 208-334-6558

September 28, 2026

Deputy Director
Center for Medicaid and CHIP Services (CMCS)

Dear Deputy Director:

The State of Idaho is submitting a reimbursement Title XIX Medicaid State Plan Amendment (SPA), Transmittal **#ID-26-0006**, through the federal OneMAC portal for the Idaho Medicaid State Plan, for reimbursement changes.

The proposed changes adjust the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) reimbursement process for change-of-scope. These requested changes are pursuant to S1410 MEDICAID (2026), which added *Idaho Code § 56-2208 Legislative Approval -- Change In Encounter Rate Due To Change In Scope Of Services*.

The State Medicaid Agency 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 State Medicaid Agency 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.

The State Medicaid Agency is requesting an effective date of October 1, 2026.

We have included the details specific to the posting of the notices, distribution methods and tribal consultation in this submission packet. A Tribal Representative Notification Letter was mailed, e-mailed, and posted to the Medicaid-Tribes website on September 24, 2026, with a specified due date of October 30, 2026, for any feedback. Public notice was provided through the statewide process, as required by 42 C.F.R. § 447.205, on September 25, 2026, with thirty (30) days for feedback.

Idaho appreciates your review of this proposed SPA, and anticipates CMS approval. Please direct any questions to Charles Beal, Medicaid Policy Chief, at charles.beal@dhw.idaho.gov.

Sincerely,

SASHA O'CONNELL
Deputy Director

SO

cc: Courtenay Savage

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 26-0006 2. STATE: ID

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10/01/2026

5. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. Part 491 Subpart A

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2027 $ 0
b. FFY 2028 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Medicaid State Plan Attachment 4.19-B pages 4, 8

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Medicaid State Plan Attachment 4.19-B pages 4, 8

9. SUBJECT OF AMENDMENT
Amendment to the State Plan to adjust the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) reimbursement process for change-of-scope.

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL

15. RETURN TO
Deputy Director
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise, ID 83720-0009

12. TYPED NAME
SASHA O'CONNELL

13. TITLE
Deputy Director

14. DATE SUBMITTED
09/28/2026

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

3) Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each center is paid the amount (on a per medical/mental encounter basis) equal to the amount paid in the previous federal fiscal year, increased by the percentage increase in the MEI for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the center during that fiscal year. Final PPS encounter rate changes are based on the incremental cost of the change in scope. The incremental impact of the change in scope is calculated as the cost of the event divided by total visits for all services inclusive of the change in scope visits. The RHC is responsible for supplying the needed documentation to the State regarding increase or decrease in the RHC scope of services. The per encounter payment rate shall include costs of all Medicaid coverable services and costs provided in the center.

4) A change in the scope of services is defined to include such things as addition of new service, deletion of existing service, or other changes in the scope/intensity of services offered by a clinic which could significantly change a clinics total allowable cost per encounter. A change in provider's cost will not qualify as a scope of service change. The Division of Medicaid or its designee will make the final determination whether or not there has been a change in the scope of services.

5) For newly qualified RHCs after federal fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers and adjustment for any increase/decrease in the scope of services furnished by the center during that fiscal year.

a) In the case of any RHC which contracts with a managed care organization, supplemental payments will be made quarterly to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system to ensure compliance with Section 1902(bb)(5)(B) of the SSA.

6) The Medicaid payment for case management under the Healthy Connections program, and for presumptive eligibility screenings shall be included in the encounter rate calculation, however shall be reimbursed separately from the encounter.

7) Effective 07/01/16, reimbursement for Long Acting Reversible Contraception (LARC) and Non-surgical Transcervical Permanent Female Contraceptive Devices shall be separate from the RHC PPS rate. In addition to payment at the PPS rate for the insertion of the device(s), RHCs will be eligible for payment for cost of the device(s) for claims with dates of service on or after 07/01/16 to be paid at the 340B acquisition cost. For device(s) not purchased through the 340B program, reimbursement shall be made at the lower of the provider's charges or the rate on the fee schedule posted at: http://www.healthandwelfare.idaho.gov. The fee schedule was last updated on 07/01/16 to be effective for services on or after 07/01/16.

reporting period to the mid-point of the prospective rate period using the Medicare Economic Index (MEI). The average of these two rates will be the prospective medical/mental and dental rates for the period 01/01/01 to 09/30/01.

3) Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each center is paid the amount (on a per medical/mental and dental encounter basis) equal to the amount paid in the previous federal fiscal year, increased by the percentage increase in the MEI for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the center during that fiscal year. Final PPS encounter rate changes are based on the incremental cost of the change in scope. The incremental impact of the change in scope is calculated as the cost of the event divided by total visits for all services inclusive of the change in scope visits. The FQHC is responsible for supplying the needed documentation to the State regarding increase or decrease in the FQHC scope of services. The per encounter payment rate shall include costs of all Medicaid coverable services and costs provided in the center.

4) A change in the scope of services is defined to include such things as addition of new service, deletion of existing service, or other changes in the scope/intensity of services offered by a clinic which could significantly change a clinics total allowable cost per encounter. A change in provider's cost will not qualify as a scope of service change. The Division of Medicaid or its designee will make the final determination whether or not there has been a change in the scope of services.

5) For newly qualified FQHCs after federal fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers and adjustment for any increase/decrease in the scope of services furnished by the center during that fiscal year.

a) In the case of any FQHC which contracts with a managed care organization, supplemental payments will be made quarterly to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system to ensure compliance with Section 1902(bb)(5)(B) of the SSA.

6) The Medicaid payment for case management under the Healthy Connections program, and for presumptive eligibility screenings shall be included in the encounter rate calculation, however shall be reimbursed separately from the encounter.

7) Effective 07/01/16, reimbursement for Long Acting Reversible Contraception (LARC) and Non-surgical Transcervical Permanent Female Contraceptive Devices shall be separate from the FQHC PPS rate. In addition to payment at the PPS rate for the insertion of the device(s), FQHCs will be eligible for payment for cost of the device(s) for claims with dates of service on or after 07/01/16 to be paid at the 340B acquisition cost. For device(s) not purchased through the 340B program, reimbursement shall be made at the lower of the provider's charges or

SPA ID-26-0006
Standard Funding Questions

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

STATE'S RESPONSE: The providers retain all of the Medicaid payments, unless at cost settlement there has been an over payment according to our reimbursement methodology. If an overpayment has been made, then the provider returns to the State Medicaid Agency the overpayment. In the unlikely event that there is an overpayment to a clinic or to physician or other practitioner's service provider, the State Medicaid Agency would recover both the federal and state portions. The State Medicaid Agency returns the federal portion to the Centers for Medicare and Medicaid services using the quarterly expenditure report.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the nonfederal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following: (i) a complete list of the names of entities transferring or certifying funds; (ii) the operational nature of the entity (state, county, city, other); (iii) the total amounts transferred or certified by each entity; (iv) clarify whether the certifying or transferring entity has general taxing authority: and, (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

STATE'S RESPONSE: Matching funds for all Medicaid payments are with state general funds appropriated by the legislature. For payments made to school districts, each school district submits to the State Medicaid Agency their local match before the State Medicaid Agency makes the payment to the schools with federal funds.

The State Medicaid Agency also makes an annual UPL payment for private nursing homes, hospitals, and ICF/IIDs and non-state government owned nursing homes and hospitals. Disproportionate Share Hospital (DSH) payment match comes from the hospital provider tax fund as well.

All nursing facility, hospital, or ICF/IID UPL match comes from the nursing facility, hospital, or ICF/IID provider tax fund.

The State Medicaid Agency is standing up the Ground Emergency Medical Transportation (GEMT) supplemental payment approved earlier this calendar year (2025). This program utilizes CPEs. This is an optional program in its first year and does not yet have CPE match amounts to report.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

STATE'S RESPONSE: Under the current approved Medicaid State Plan for supplemental payments related to the Upper Payment Limit (UPL), the State Medicaid Agency paid private nursing facilities $27,094,04 (federal funds and nursing facility provider tax amounts for the match) in November 2022. The State Medicaid Agency paid government owned nursing facilities $3,131,572 (federal funds and nursing facility provider tax amounts for the match) in November 2022.

Under the current approved State Plan for supplemental payments related to the Upper Payment Limit (UPL), the State Medicaid Agency paid non-state government owned hospitals, including critical access hospitals and district hospitals $5,425,438.00 (federal funds and hospital provider tax amounts for the match) in June 2025. The State Medicaid Agency paid private hospitals $319,481,040.00 (federal funds and hospital provider tax amounts for the match) in June 2025.

Under the current approved State Plan for supplemental payments related to the Upper Payment Limit (UPL), the State Medicaid Agency paid private ICF/IID providers $9,083,772 (federal funds and hospital provider tax amounts for the match) in September 2025.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately

owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

STATE'S RESPONSE: To begin with, the providers are separated into ownership classes (as shown above). In calculating the UPL gap, first the State Medicaid Agency figures out how much Medicaid paid. Then the State Medicaid Agency calculates what Medicare would have paid, the assumption is that MCR pays 100% of cost. The State Medicaid Agency inflates this from the mid-point of the cost report year to the mid-point of the UPL period. The difference between these two numbers is the UPL gap. Distribution of OP UPL gap is based on actual payments made during the period and are allocated based on the weight of payments for each provider.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

STATE'S RESPONSE: It does not matter whether it is public or private; if at the time of settlement, a nursing facility was over paid, the dollars are recouped, and the federal portion is returned on the quarterly expenditure report.