Table of Contents

State/Territory Name: Idaho

State Plan Amendment (SPA) #: 21-0017

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS Form 179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

March 18, 2022

Ms. Juliet Charron
Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 8320
Boise, ID 83720-0009

Re: Idaho State Plan Amendment (SPA) 21-0017

Dear Administrator Charron:

We have reviewed the proposed amendment to add section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) 21-0017. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq*.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and this state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 430.20 that the state submit SPAs related to the COVID-19 public health emergency by the final day of the quarter, to obtain a SPA effective date during the quarter, enabling SPAs submitted after the last day of the quarter to have an effective date in a previous quarter, but no earlier than the effective date of the public health emergency.

The State of Idaho also requested a waiver of public notice requirements applicable to the SPA submission process. Pursuant to section 1135(b)(1)(C) of the Act, CMS is waiving public notice requirements applicable to the SPA submission process. Public notice for SPAs is required under 42 C.F.R. §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to Alternative Benefit Plans (ABPs). Pursuant to section 1135(b)(1)(C) of the Act, CMS is approving the state's request to waive these notice requirements otherwise applicable to SPA submissions.

The State of Idaho also requested a waiver to modify the tribal consultation timeline applicable to this SPA submission process. Pursuant to section 1135(b)(5) of the Act, CMS is also allowing states to modify the timeframes associated with tribal consultation required under section 1902(a)(73) of the Act, including shortening the number of days before submission or conducting consultation after submission of the SPA.

These waivers or modifications of the requirements related to SPA submission timelines, public notice, and tribal consultation apply only with respect to SPAs that meet the following criteria: (1) the SPA provides or increases beneficiary access to items and services related to COVID-19 (such as by waiving or eliminating cost sharing, increasing payment rates or amending ABPs to add services or providers); (2) the SPA does not restrict or limit payment or services or otherwise burden beneficiaries and providers; and (3) the SPA is temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 public health emergency (or any extension thereof). We nonetheless encourage states to make all relevant information about the SPA available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that Idaho's Medicaid SPA Transmittal Number 21-0017 is approved effective April 1, 2021. This SPA is in addition to the Disaster Relief SPAs approved on September 3, 2020, April 30, 2021, and May 28, 2021 and does not supersede anything approved in those SPAs.

Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact Courtenay Savage by email at courtenay.savage@cms.hhs.gov or at 312-353-3721 if you have any questions about this approval. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of Idaho and the health care community.

Sincerely,

Alissa M. Deboy -S

Digitally signed by Alissa M. Deboy -S
Date: 2022.03.18 07:49:50 -04'00'

Alissa Mooney DeBoy
On Behalf of Anne Marie Costello, Deputy Director
Center for Medicaid and CHIP Services

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **ID 21-0017**

2. STATE: **IDAHO**

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
04-01-2021

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE REGULATION CITATION:
SSA §1915(i) / 42 CFR 441 Subpart M
SSA §1135
SSA §1905
Section 1905 of the Social Security Act & Title 19*

7. FEDERAL BUDGET IMPACT:
FFY 21 $0
FFY 22 $78,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
7.4 Medicaid Disaster Relief SPA Template*

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
N/A

10. SUBJECT OF AMENDMENT:
Disaster Relief SPA to temporarily modify payments to providers in line with the state's American Rescue Plan Home and Community Based Services (HCBS) Spending Plan.

11. 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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Juliet Charron

14. TITLE:
Administrator

15. DATE SUBMITTED:
12-02-2021

16. RETURN TO:
Juliet Charron, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0009

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 2, 2021

18. DATE APPROVED:
March 18, 2022

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL:
Alissa M Deboy -S
Digitally signed by Alissa M Deboy -S
Date: 2022.03.18 07:50:18 -04'00'

21. TYPED NAME:
Alissa Mooney DeBoy

22. TITLE:
On Behalf of Anne Marie Costello, Deputy Director, CMCS

23. REMARKS:

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. X **SPA sub**mission requirements – the agency requests modification of the requirement to submit the SPA by June 30, 2021, to obtain a SPA effective date during the second calendar quarter of 2021, pursuant to 42 CFR 430.20.

b. X **Public notice require**ments – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans),

42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. **X** **Tribal consultation requirements** – the agency requests modification of tribal consultation timelines specified in **Idaho** Medicaid state plan, as described below:

Idaho's Tribal Consultation Requirements read: "Timeframe for Consultation: The State will request consultation at the earliest opportunity and to the extent possible give the appropriate tribal and Indian health provider contact(s) an appropriate amount of time to consider and respond to the impact of the consultation request. Whenever possible, the State will provide notification to the Tribes and Indian health providers 60 days prior to submission and allow 30 days for response. Whenever possible, in expedited circumstances, 14 day notice will be given with 7 days allowed for response. The request may be in writing or communicated verbally as part of a quarterly Tribal meeting."

Idaho requests to modify requirements laid out under the timeframe for consultation section, including conducting consultation after submission. Idaho will identify this SPA at the next Quarterly Tribal meeting on February 16, 2022, and will provide opportunity for discussion with Tribal Representatives.

Section A – Eligibility

1. _____ **The agency furnishes** medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

2. _____ **The agency furnishes** medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. _____ **All individuals who are described in section 1905(a)(10)(A)(ii)(XX)**

   Income standard: _____

   -or-

   b. _____ **Individuals described in the following categorical populations in section 1905(a)** of the Act:

This SPA is in addition to the Disaster Relief SPAs approved on September 3, 2020; April 30, 2021, and May 28, 2021 and does not supersede anything approved in those SPAs.

Income standard: _____

3. _____ **The agency applies less restrictive financial** methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ **The agency considers individuals who are evacuated fro**m the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ **The agency provides** Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ **The agency provides for an extension of the reasonable opportunity period for non-**citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ **The agency elects to allow hospitals to** make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110,

provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ **The agency designates itself as a qualified entity for purposes of** making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ **The agency designates the following entities as qualified entities for purposes of** making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ **The agency adopts a total of** _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ **The agency conducts redeter**minations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ **The agency uses the following si**mplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ **The agency uses a si**mplified paper application.

    b. _____ **The agency uses a si**mplified online application.

c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

2. ___ The agency suspends enrollment fees, premiums and similar charges for:

   a. _____ All beneficiaries

   b. ___ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. ____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. ____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ **The agency** makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ **The agency** makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ **Newly added benefits described in Section D are paid using the following** methodology:

   a. _____ **Published fee schedules –**

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. _____ **Other:**

Describe methodology here.

Increases to state plan payment methodologies:

2. __X__ **The agency increases** payment rates for the following services:

Please list all that apply.
Services as specified in the state's submitted ARP HCBS Spending Plan. • **Adult Day Health** • **Adult Residential Care** • **Assessment and Clinical Treatment Plan** • **Attendant Care** • **Behavior Consultation/Crisis Management** • **Behavioral Assessment**

This SPA is in addition to the Disaster Relief SPAs approved on September 3, 2020; April 30, 2021, and May 28, 2021 and does not supersede anything approved in those SPAs.

- Behavioral Intervention
- Behavioral Modification and Consultation
- Children's Habilitation Crisis Intervention
- Chore Services
- Community Based Supports
- Community Support Services (Participant Direction)
- Companion
- Comprehensive Diagnostic Assessment
- Consultation
- Crisis Centers
- Crisis Intervention
- Crisis Response
- Day Habilitation
- Developmental Therapy
- Family Directed Community Supports
- Family Education
- Family Psychoeducation
- Family Support
- Financial Management Services
- Habilitative Skills Building
- Home Delivered Meals
- Home Health: Home Health Aide
- Home Health: Occupational Therapy
- Home Health: Physical Therapy
- Home Health: Skilled Nursing
- Home Health: Speech-Language Pathology
- Homemaker Services
- Individualized Treatment Planning
- Intensive Outpatient Program
- Medication Management
- Nursing Services
- Peer Support/Recovery Coaching
- Personal Care Services
- Private Duty Nursing
- Psychological and Neuropsychological Testing
- Psychotherapy (Individual, Family, Group)
- Residential Habilitation
- Respite Care
- Respite Care for families of a child with serious emotional disturbance
- Skilled Nursing
- Skilled Nursing (not Home Health)
- Skills Building /Community Based Rehabilitative Services
- Skills Training and Development (STAD)
- Substance Use Assessment
- Support Broker

This SPA is in addition to the Disaster Relief SPAs approved on September 3, 2020; April 30, 2021, and May 28, 2021 and does not supersede anything approved in those SPAs.

- Support Broker Services
- Supported Employment
- Targeted case management for adults with developmental disabilities
- Targeted case management for at-risk children (home visiting)
- Targeted case management for children with special health care needs
- Targeted case management for people with behavioral health needs
- Transition Services
- Youth Support

a. **X** Payment increases are targeted based on the following criteria:

Please describe criteria.

Home and community-based providers that provided certain HCBS services between July 1, 2018 through March 31, 2021 and are currently enrolled and in good standing with Medicaid shall receive a temporary, one-time lump-sum increase to any regular provider rate reimbursement based on submitted claims otherwise received from the Division of Medicaid for home and community-based services. The lump-sum payment funded by the American Rescue Plan 10% FMAP increase for the period April 1, 2021 through March 31, 2022 shall not exceed the provider's claim expenditures during the "HCBS Program Improvement Period" defined by ARPA section 9817. The lump-sum funding payment will be available to HCBS providers as outlined and appropriated in House Bill 382 (2021), or until funds appropriated for this purpose are expended or the ARP HCBS claim expenditure for the 10 percent enhanced match is exhausted, not to exceed the end date of the federal Public Health Emergency (PHE). This increase shall be used solely for temporary pay increases or bonuses for direct care workers subject to guidance from CMS and federal limitations for the funds.

b. Payments are increased through:

i. **X** A supplemental payment or add-on within applicable upper payment limits:

Please describe.

Each payment to provider is based on historical expenditures from July 1, 2018 – March 31, 2021, with payments dependent on the provider maintaining the specific service in the most current state fiscal year during the "HCBS Program Improvement Period." To calculate the lump-sum payment, Idaho Medicaid calculated the total expenditures per unique procedure codes, count of providers billing the unique procedure code by NPI, and total expenditures for all procedure codes. This ARP HCBS H382 payment is voluntary for providers. Eligible providers must sign an

attestation letter agreeing to the terms and conditions of the payment prior to issuance of the lump-sum payment.

Definitions:

- Anticipated Payment: The proposed state directed lump sum payment. Based on methodology of percentage of historical expenditures, provider claim expenditures, and House Bill 382 allocation to Idaho Medicaid. (See below for example of methodology and payment calculation)
- Attestation Letter: Statement of acknowledgement for eligible providers to sign, affirming the understanding of limitations of lump-sum payment. Required by House Bill 382 (2021).
- Bonuses: An amount of dollars given to a direct care worker on top of their regular earnings.
- Direct Care Workers: Individuals employed or contracted by HCBS providers/entities to provide "hands-on" care and services to an enrolled Idaho Medicaid participant.
- Eligible Providers: Individuals/entities that currently bill Idaho Medicaid through a fee-for-service provider contract.
- Good Standing: Providers/Organizations not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from receiving funding by a federal or state government entity.
- Historical Expenditures/HCBS Expenditures: The amount Idaho Medicaid spent on HCBS services for Idaho Medicaid participants for the period July 1, 2018 through March 31, 2021 to inform the anticipated lump-sum payment to providers.
- House Bill 382 (2021): State legislative requirements for Idaho Medicaid and Idaho Medicaid providers in the appropriation and distribution of ARP HCBS funding. Bill restricts ARP HCBS funding to be used for direct care worker wage increases and bonuses.
- Lump-sum payment (ARP HCBS H382 payment): The voluntarily, state directed payment made in addition to established fee-for-service provider rate reimbursement. The payment is separate and distinct from rates, and based on historical expenditures.
- New Providers: Individuals or entities with a newly signed contract to provide HCBS services to Idaho Medicaid participants between July 1, 2019 through March 31, 2021.
- Procedure Code Expenditure [Data]: The sum of all providers' claims expenditures for the unique service/care rendered to an Idaho Medicaid participant. (See below for example).
- Procedure Code Percentage: The calculation used to inform a piece of the lump-sum payment/anticipated payment. The percentage is calculated by dividing the unique procedure code by the total HCBS expenditures. (See below for example).

- Provider's Claim Expenditures: The amount Idaho Medicaid reimbursed/paid the individual/entity for healthcare and related activities for care/services to Idaho Medicaid participants in a 12-month period.
- SFY 2019 Base: Starting point for historical total of HCBS providers and expenditures to inform the ARP HCBS H382 lump-sum payment to eligible providers. State Fiscal Year 2019 for Idaho Medicaid is the period July 1, 2018 through June 30, 2019.
- Specific Service: Provider/Organization delivering home and or community-based care tied back to a billed procedure code. (e.g. Residential Assisted Living Facility providing Adult Day Health or Personal Assistance Agency providing Chore Services to Idaho Medicaid participant(s)).
- Temporary Pay Increases: An amount of dollars in addition to a direct care worker's base salary and does not become a part of the direct care worker's base salary. When funding expires or anticipated provider payment from ARP HCBS funding is exhausted, the temporary pay increase may be withdrawn.
- Total Expenditures: The amount Idaho Medicaid spent on healthcare and related activities for care/services to Idaho Medicaid participants for the period of July 1, 2018 through March 31, 2021.

Steps:

1: Idaho collects FFS procedure code expenditure data from July 1, 2018 through June 30, 2019 for currently active providers. Active defined as currently providing services during the "HCBS Program Improvement Period" defined by ARPA section 9817. This is SFY 2019 base.

2: Idaho collects FFS procedure code expenditure data from SFY 2020 to add new providers and add procedure codes from existing providers (if applicable) to SFY 2019 base.

3: Idaho collects FFS procedure code expenditure data from July 1, 2020 through March 31, 2021 to add new providers and add procedure codes from existing providers (if applicable) to SFY 2019 base.

4: Steps 1 – 3 will complete the adjusted base expenditures for HCBS services to determine the total HCBS expenditures and total procedure code expenditures for all providers (FFS).

5: Each procedure code total will be divided by the total expenditure to identify an overall percent of HCBS expenditures per procedure code.

6: The procedure code percentage will be multiplied by $57M to determine the allocation of H382.

7: The provider's procedure code expenditures will be divided by the total procedure code expenditures to get a percentage.

8: The provider's procedure code expenditure percentage calculated in Step 7 will be multiplied by the allocation of H382 for that procedure code (from Step 6).

9: The provider's anticipated payment will be calculated per procedure code and totaled for a lump-sum payment.

Example:

HCBS FFS Provider A: bills to procedure codes 0421, 0431
HCBS FFS Provider B: bill to procedure code 0431

HCBS Total Expenditures, all FFS procedure codes: $447,175,563.25
HCBS FFS Total Expenditures, procedure code 0421: $2,266,117.59
HCBS FFS Total Expenditures, procedure code 0431: $*1,041,323.41*

Provider A:
Provider Total Expenditures, procedure code 0421: $656,269.06
Provider Total Expenditures, procedure code 0431: $1,041,323.41

0421: ($656,269.06/$2,266,117.59) = (.2896) * ($288,746.13) = $83,620.88
*0431: ($910.53/$1,041,323.41) = (.0009) * ($132,684.25) = $116.02*
Provider A Lump Sum: $83,736.90

Provider B:
Provider Total Expenditures, procedure code 0431:
0431: ($107,810.72/$1,041,323.41) = (.1035) * ($132,684.25) = $13,737.12
Provider B Lump Sum: $13,737.12

Note: This Disaster SPA ARP Update submission is requesting approvals for fee-for-service activities and providers only. Although managed care providers do bill these services and make up a portion of the HCBS provider network (~30%), the state is working with CMS Managed Care Technical Assistance groups on approvals for the state-directed payment option and working on a 438.6(c) preprint. The Disaster SPA ARP Update is not intended to get approval on any MCO activities or payments, and the calculations made do not include any MCO data or expenditures.

ii. _____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. _____ Are not otherwise paid under the Medicaid state plan;

   b. _____ Differ from payments for the same services when provided face to face;

   c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

   d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

   a. _____ The individual's total income

   b. _____ 300 percent of the SSI federal benefit rate

   c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05,

Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

This SPA is in addition to the Disaster Relief SPAs approved on September 3, 2020; April 30, 2021, and May 28, 2021 and does not supersede anything approved in those SPAs.