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State/Territory Name: ID

State Plan Amendment (SPA) ID: 23-0014

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

January 17, 2025

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

RE: TN 23-0014

Dear Administrator Charron:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Idaho state plan amendment (SPA) to Attachment 4.19-B ID 23-0014, which was submitted to CMS on March 28, 2023. This plan amendment creates a reimbursement methodology for supplemental payment for ground emergency medical transportation services.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of January 26, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact LaJoshica (Josh) Smith at 214-767-6453 or via email at lajoshica.smith@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN 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: 23-0014

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
~~01-01-2023~~ 01/26/2023

5. FEDERAL STATUTE/REGULATION CITATION
Section 1902(a)(70) of the Social Security Act
Title XIX of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0
b. FFY 2024 $ 20,000,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B pages ~~35-35d~~ 35a-35c (NEW)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
~~Attachment 4.19-B page 35~~

9. SUBJECT OF AMENDMENT
Amendment to the State Plan for reimbursement methodology for supplemental payment for ground emergency medical transportation services provided by providers owned or operated by the state or a political subdivision of the state.

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
[redacted]

12. TYPED NAME
JULIET CHARRON

13. TITLE
Administrator

14. DATE SUBMITTED
03/28/2023

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

FOR CMS USE ONLY

16. DATE RECEIVED 03/28/2023

17. DATE APPROVED
January 17, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
01/26/2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

Pen and Ink change for Block 4 to adjust Proposed Effective Date
Pen and Ink change for Block 7 & Block 8 to adjust page numbers

Instructions on Back

e. Supplemental Reimbursement For Ground Emergency Medical Transportation (GEMT):

Effective January 1, 2023, Ground Emergency Medical Transportation (GEMT) providers that meet the specified requirements outlined below and provide GEMT services to Medicaid beneficiaries will be eligible for a supplemental payment. This supplemental payment applies to Emergency Transportation Services rendered to Medicaid beneficiaries by eligible GEMT providers on or after January 1, 2023.

The GEMT Supplemental Reimbursement Program is a voluntary program and GEMT providers are not required to participate.

Supplemental payments provided by this program are available only for allowable costs that are in excess of Medicaid reimbursement rates paid to GEMT providers in accordance with Attachment 4.19-B that eligible entities receive for GEMT services rendered to eligible Medicaid recipients. Total reimbursements under the GEMT program are capped (including supplemental payments) at one hundred percent (100%) of actual costs. The State Medicaid Agency will recognize a supplemental payment equal to the total allowable Medicaid costs of eligible governmental ambulance providers for providing services as set forth below.

1. A provider shall be eligible for supplemental reimbursement only if, during the state fiscal year, the provider:

   a. Provides ground emergency medical transportation services to Medicaid beneficiaries;

   b. Is enrolled as a Medicaid provider for the period being claimed and;

   c. Is owned or operated by the state or a political subdivision of the state that employs or contracts with persons who are licensed to provide emergency medical services in the state of Idaho.

   Providers meeting all these qualifications will be considered “Eligible Providers.”

2. Supplemental Reimbursement Methodology – General Provisions

   a. Computation of allowable costs and allocation methodologies must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, Medicare cost reimbursement principles in 42 CFR Part 413 and Section 1861 of the Social Security Act, and 2 CFR Part 200 as implemented by HHS at 45 CFR Part 75, which establish principles and standards for determining allowable costs and the methodology for allocation and apportioning those expenses to the Medicaid program, except as expressly modified below.

   b. The difference between reimbursement and costs of each Eligible Provider available to be reimbursed under this supplemental reimbursement program will equal the shortfall resulting from the allowable costs determined using the Cost Determination Protocols for each Eligible Provider providing GEMT to Idaho Medicaid participants, net of the amounts received and payable from the Idaho Medicaid program and all other sources of reimbursement for such services provided to Idaho Medicaid participants. If the Eligible Providers do not have any shortfall, then the provider will not receive a supplemental payment under this supplemental reimbursement program.

3. Cost Determination Protocols

   a. An Eligible Provider’s specific allowable cost per-GEMT service rate will be calculated based on the provider’s financial data reported on the state-approved cost report. The per-GEMT service cost rate will be the sum of actual allowable direct and indirect costs of providing GEMT services divided by the actual number of GEMT services provided for the applicable service period.

i. The cost report will include Direct Cost consistent with 2 CFR 200.413 and 2 CFR 200.405 which may include costs such as ambulance depreciation, salaries and benefits of paramedics and Emergency Medical Technicians (EMTs) providing GEMT services and medical supplies utilized in the delivery of GEMT services. Direct cost centers which support GEMT in addition to one or more non-GEMT functions, must be allocated.

1. Direct costs can be reported if discretely tracked to GEMT services and otherwise in alignment with the definition of Direct Cost in 2 CFR 200.413. Unlike indirect costs as defined in 45 CFR 75.2, all direct costs must be readily assignable to GEMT, without effort disproportionate to the results achieved.

2. The cost of personnel providing GEMT in addition to other programs and services can be allocated based on a percentage of total hours logged performing GEMT activities versus activities identified with other cost objectives.

ii. The costs and related basis used to determine the allocated indirect costs must comply with Medicaid cost principles specified within 2 CFR Part 200. Indirect costs are determined in one of two ways for each cost report period:

1. GEMT providers with a federally approved indirect cost rate may apply the cognizant agency specific approved indirect cost rate to the total direct costs.

2. GEMT providers that do not have a cognizant agency specific approved indirect cost rate may identify indirect costs by applying the prevailing de minimis rate for the applicable service period to the total direct costs.

iii. All costs associated with a direct service cost objective other than GEMT that are readily assignable to the cost objectives specifically benefitted must be reported as unallowable.

iv. The provider specific per-GEMT service cost rate is calculated by dividing the total net GEMT services allowable costs of the specified provider by the total number of GEMT services provided by the provider for the applicable service period.

4. Cost Settlement Process

a. The payments and the number of GEMT services reported in the as-filed cost report will be reconciled with the Department's Medicaid Management Information System (MMIS) reports generated for the cost reporting period within twelve (12) months of the cost report deadline. The Department will make adjustments to the as-filed cost report based on the reconciliation results of the most recently retrieved MMIS report.

b. Each Eligible Provider will receive an annual lump sum payment in an amount equal to the total of the Medicaid shortfall, as defined above.

c. The Department will perform a final reconciliation where it will settle the Eligible Provider's annual cost report, as reviewed by the agency. The Department will compute the net GEMT allowable costs using reviewed and/or audited per-GEMT cost, and the number of fee-for-service GEMT services reflected in the updated MMIS reports. Actual net allowable costs will be compared to the total Medicaid reimbursement paid to the provider for eligible services, including claims payments, third party liability, copayments, settlement payments made, and any other source of reimbursement received by the Eligible Provider for the period for applicable Medicaid services. If, at the end of the final reconciliation, it is determined that the Eligible Provider has been overpaid, the provider will return the overpayment to the State Medicaid Agency and the State Medicaid Agency will return the overpayment to the federal government pursuant to 42 CFR 433.316. If an underpayment is determined, then the Eligible Provider will receive a final supplemental payment in the amount of the underpayment.

5. Eligible Provider Reporting Requirements

a. Providers must file an annual cost report for the period of the federal fiscal year spanning October to September. Cost reports are due no later than six months after the last day of the cost report period. A request for an extension shall only be approved when a provider's operations are significantly and/or adversely affected due to extraordinary circumstances. The written request must include a detailed explanation of the circumstances supporting the need for additional time and be postmarked within the six months after the last day of the applicable reporting period. Filing extensions may be granted by the State Medicaid Agency for good cause and at its discretion.

b. Only cost reports from Eligible Providers will be accepted.

c. Participating Eligible Providers who meet the required state enrollment criteria are eligible for federal reimbursement up to reconciled cost for services provided on or after January 1, 2023.

i. Eligible Providers will be paid interim rates equal to the Medicaid reimbursement rates paid to other GEMT providers in accordance with Attachment 4.19-B. The interim rates are provisional in nature, pending the submission of an annual cost report and the completion of cost reconciliation and a cost settlement for that period. Settlements are a separate transaction, occurring as an adjustment to prior year costs and are not to be used to offset future rates.

ii. Eligible Providers will submit a state approved cost report annually, on a form approved by the State Medicaid Agency.

iii. "Allowable costs" will be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, Medicare cost reimbursement principles in 42 CFR Part 413 and Section 1861 of the Social Security Act, and 2 CFR Part 200 as implemented by HHS at 45 CFR Part 75.

1. "Direct costs" are those costs that are identified by 45 CFR 75.413 that:

a. Can be identified specifically with a particular final cost objective (to meet emergency transportation service requirements), such as a federal award, or other internally or externally funded activity; or

b. Can be directly assigned to such activities relatively easily with a high degree of accuracy.

2. "Indirect costs" means the costs that cannot be readily assigned to a particular cost objective and are those that have been incurred for common or joint purposes.

iv. Eligible Provider's reported direct and indirect costs are allocated to the Medicaid program by applying a Medicaid utilization statistic ratio. The Medicaid utilization statistic ratio is based on billing data associated with the dates of service covered by the submitted cost report.