IDAPA 16 – IDAHO DEPARTMENT OF HEALTH AND WELFARE

Division of Medicaid

16.03.18 – Medicaid Cost-Sharing

Who does this rule apply to?
For those receiving medical assistance under Idaho Medicaid who are subject to cost-sharing.

What is the purpose of this rule?
These rules describe the general requirements regarding the administration of the cost-sharing provisions for participation in a medical assistance program providing direct benefits in Idaho.

What is the legal authority for the agency to promulgate this rule?
This rule implements the following statutes passed by the Idaho Legislature:

Public Assistance and Welfare -
Public Assistance Law:
- Section 56-202(b), Idaho Code – Duties of Director of State Department of Health & Welfare
- Section 56-253, Idaho Code – Powers and Duties of the Director
- Section 56-257, Idaho Code – Copayments

Where can I find information on Administrative Appeals?
Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."

How do I request public records?
Unless exempted, all public records are subject to disclosure by the Department that will comply with Title 74, Chapter 1, Idaho Code, upon requests. Confidential information may be restricted by state or federal law, federal regulation, and IDAPA 16.05.01, "Use and Disclosure of Department Records."

Who do I contact for more information on this rule?

Idaho Department of Health and Welfare
Division of Medicaid – Medicaid Cost-Sharing
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Boise, ID 83702

P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5747 or 1-877-200-5441 (toll free)
Fax: (208) 364-1811
Email: Medicaid.Rules@dhw.idaho.gov
Webpages: Medicaid: https://medicaid.idaho.gov
https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers
(see Public Schedule of Premiums and Cost-Sharing)

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16.03.18 – Medicaid Cost-Sharing

000. LEGAL AUTHORITY.
Under Section 56-202(b), Idaho Code, the Department establishes and enforces rules necessary to administer public assistance programs. Under Sections 56-253, 56-255 and 56-257, Idaho Code, and 42 CFR Part 447 Payments for Service the Department establishes enforceable cost-sharing requirements within the limits of federal Medicaid law and regulations.The Department is the designated agency to administer programs under Title XIX and Title XXI of the Social Security Act. (7-1-24)

002. -- 009. (RESERVED)

010. DEFINITIONS.
In addition to definitions under Section 56-252, Idaho Code, the following definitions apply: (7-1-24)

01. Copayment (Copay). The amount a participant pays a provider for specified services. (7-1-24)

02. Department. The Idaho Department of Health and Welfare, or its designee. (7-1-24)

03. Federal Poverty Guidelines (FPG). Guidelines issued annually by the U. S. Department of Health and Human Services (HHS) at http://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines. (7-1-24)

04. Physician Office Visit. Services provided to a participant by a physician, nurse practitioner, or physician's assistant. (7-1-24)

05. Premium. A regular and periodic charge or payment for health coverage. (7-1-24)

011. -- 024. (RESERVED)

025. PARTICIPANTS NOT ALREADY FEDERALLY EXEMPT FROM COST-SHARING.
Participants in the Medicaid Workers with Disabilities (MWD) program are exempt from the cost-sharing provisions of Sections 200, 205, 207, and 400 of these rules. (7-1-24)

026. -- 049. (RESERVED)

050. GENERAL COST-SHARING.

01. Proof of Cost-Sharing Payment. If a participant believes their cost-sharing exceeded five percent (5%) of gross monthly household income, they must provide proof to the Department for an assessment of suspension or reimbursement. (7-1-24)

02. Excess Cost-Sharing. A household that establishes proof of payment for cost-sharing that exceeds five percent (5%) of gross monthly household income will be reimbursed by the Department for the amount paid that exceeds the five percent (5%), except as provided in this rule. (7-1-24)

03. Cost-Sharing Suspended. A household that exceeds the five percent (5%) maximum amount for cost-sharing for the calendar month is not required to pay cost-sharing for any household member for the remainder of the calendar month. (7-1-24)

051. - 199. (RESERVED)

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

01. Household Income Above 133% of FPG. Participants with household income above one hundred thirty-three percent (133%) and equal to or less than one hundred fifty percent (150%) of the current FPG pay a monthly premium of ten dollars ($10) to the Department. (7-1-24)

02. Household Income Above 150% of FPG. Participants with household income above one hundred fifty percent (150%) and equal to or less than one hundred eighty-five percent (185%) of the current FPG pay a monthly premium of fifteen dollars ($15) to the Department. (7-1-24)

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

the premium is recalculated. The Department waives any premium for participants who become eligible for Title XIX Medicaid. (7-1-24)

04. Premium Reduction. The monthly premium for SCHIP participants may be reduced by ten dollars ($10) per month under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (7-1-24)

201. -- 204. (RESERVED)

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

01. Household Income Above 150% and Equal to or Less Than 185% of FPG. Participants with household income above one hundred fifty percent (150%) and equal to or less than one hundred eighty-five percent (185%) of the current FPG pay a monthly premium of fifteen dollars ($15). The maximum monthly premium is limited to thirty dollars ($30). (7-1-24)

02. Household Income Above 185% of FPG. Participants with income above one hundred eighty-five percent (185%) of the current FPG pay a monthly premium. The monthly premium is a fixed percentage of household income as provided in the table below.

TABLE 205.02
SLIDING FEE SCHEDULE FOR MONTHLY PREMIUMS FOR HCCDC PARTICIPATION

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

(7-1-24)

03. Failure to Provide Information. Failure to provide the Department with information to determine eligibility may subject the participant to a monthly premium equal to the average monthly cost of coverage for participants receiving Medicaid Enhanced Plan Benefits through HCCDC. (7-1-24)

04. Failure to Pay Premium. Failure to pay the premium will not cause the participant to lose coverage or eligibility for services. (7-1-24)

05. Waiver of Premium. The premium is waived if the Department determines payment of the premium would cause undue hardship. Undue hardship exists when an unexpected expense would cause the household to forgo basic food or shelter to make a premium payment. Detailed documentation of the household's living expenses demonstrating such hardship must be provided to the Department. (7-1-24)

06. Premium Recalculation. Premiums are recalculated at each annual eligibility determination. If the Department receives verification of a reduction in household income prior to annual redetermination, the premium is recalculated. (7-1-24)

206. (RESERVED)

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

01. Premium Fee Schedule. Participants are subject to assessment of a premium. The Department establishes a premium fee schedule that is published on the Department's website at https://healthandwelfare.idaho.gov/services-programs/medicaid-health. (7-1-24)

02. Waiver of Premium. The monthly premium under this rule is waived if the Department determines the household is unable to participate in the cost of care. (7-1-24)

03. Premium Recalculation. The premium amount is recalculated at each annual eligibility redetermination. (7-1-24)

208. -- 209. (RESERVED)

210. DEPARTMENT RESPONSIBILITIES.

01. Assessed Premiums. A participant is not assessed premiums during the initial eligibility determination. Obligation for premium payments does not begin for at least sixty (60) days after receipt of application, except for workers with disabilities under these rules. (7-1-24)

02. Premiums Not Assessed Due to Late Review. A participant cannot be assessed premiums for extra months of eligibility received due solely to the Department's untimely review of continuing eligibility, except for workers with disabilities under these rules. (7-1-24)

03. No Retroactive Premiums Assessed. A participant cannot be assessed premiums for months of retroactive eligibility. (7-1-24)

04. Notification of Premiums. The Department routinely notifies participants of their premium payment obligations including any delinquencies, if applicable. (7-1-24)

211. -- 214. (RESERVED)

215. PREMIUMS FOR PARTICIPATION IN MEDICAID WORKERS WITH DISABILITIES.

01. Workers with Disabilities. Countable income is determined under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." The monthly premium is a fixed percentage of countable income as provided on the Department's website at https://healthandwelfare.idaho.gov/services-programs/medicaid-health. (7-1-24)

02. Recomputed Premium Amount. Premium amounts are recomputed when changes to a participant's countable income result in a different percentage premium calculation as determined in this rule, and at the annual re-determination. (7-1-24)

216. -- 249. (RESERVED)

250. DELINQUENT PREMIUM PAYMENTS.
If the participant is sixty (60) days or more past due on premium payments, the participant is contacted to determine the reason for the delinquency. If the participant's income is less than the amount used for the most recent eligibility determination, the participant is offered a new eligibility determination. The change is effective the month after the participant becomes eligible for such benefits. (7-1-24)

01. Delinquent Payments. A participant is not approved for or renewed for coverage that requires premium payments, if their premium payments are sixty (60) days or more delinquent. (7-1-24)

02. Reestablishing Eligibility. A participant can reestablish eligibility by paying the premium debt in full, unless forgiven in this rule. (7-1-24)

03. Premium Debt. Any premium debt assessed, but not paid, will be forgiven if one (1) of the following applies: (7-1-24)

a. The participant reports and the Department determines that the participant's household income is below one hundred and thirty-three percent (133%) FPG. This may occur at any time during the eligibility period; or (7-1-24)

b. A participant in the Medicaid Basic Plan has a medical condition that requires the participant to receive the benefits provided in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-24)

251. -- 299. (RESERVED)

300. PARTICIPANTS EXEMPT FROM COPAYMENT NOT ALREADY FEDERALLY EXEMPTED.
This includes participants who have other health care coverage that is the primary payor for the services provided. (7-1-24)

301. -- 309. (RESERVED)

310. COPAYMENT FEE AMOUNTS.
The Copayment fee amount required to be paid by the participant, when applicable, is three dollars and sixty-five cents ($3.65). (7-1-24)

311. -- 319. (RESERVED)

320. SERVICES SUBJECT TO COPAYMENTS.
Participants are responsible for making copayments unless otherwise exempt or exempted under this rule for the following. (7-1-24)

01. Accessing Hospital Emergency Department for Non-Emergency Medical Conditions. (7-1-24)

02. Accessing Emergency Transportation Services for Non-Emergency Medical Conditions. (7-1-24)

03. Chiropractic Services. (7-1-24)

04. Occupational Therapy, Speech or Physical. (7-1-24)

05. Optometric Services. (7-1-24)

06. Outpatient Hospital Services. (7-1-24)

07. Podiatry Services. (7-1-24)

08. Physician Office Visit. Each physician office visit, unless the visit is for: (7-1-24)

a. A preventive service, including wellness exams, immunizations, or family planning. (7-1-24)

b. Urgent care provided at a clinic billing as an urgent care facility. (7-1-24)

321. -- 324. (RESERVED)

325. EXCEPTION TO CHARGING A COPAYMENT.
A provider may charge a copayment if the Medicaid reimbursement for the services rendered is equal to or greater than ten (10) times the amount of the copayment under these rules. (7-1-24)

326. -- 329. (RESERVED)

330. COLLECTION OF COPAYMENTS.

01. Responsibility for Collection. The provider is responsible for collection of the copayment from the participant. (7-1-24)

02. Denial of Services. The provider may require payment of applicable copayment before rendering services. (7-1-24)

03. Waiver of Copayment. The provider may waive payment of any copayment. The provider must have a written policy describing the criteria for waiving or enforcing collection of copayments. (7-1-24)

04. Reduction in Reimbursement.When a copayment is applicable, the provider's reimbursement is reduced by the amount of the copayment regardless of whether a copayment was charged or collected by the provider. (7-1-24)

331. -- 399. (RESERVED)

400. PARTICIPATION IN THE COST OF HOME AND COMMUNITY-BASED WAIVER SERVICES (HCBS).
Participants required to participate in the cost of HCBS services as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," must have their share of cost determined under this rule. (7-1-24)

01. Excluded Income. Income excluded under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," is excluded in determining participation. (7-1-24)

02. Base Participation Amount. The base participation amount is income available to the participant after subtracting all allowable deductions, except for the incurred medical expense in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." (7-1-24)

03. Personal Needs Allowance (PNA). The participant's PNA depends on the participant's legal obligation to pay rent or mortgage and is deducted from countable income after income exclusions and any incurred medical expenses allowances. (7-1-24)

a. PNA for participants not responsible for rent or mortgage equals one hundred percent (100%) of the federal SSI benefit. (7-1-24)

b. PNA for participants responsible for rent or mortgage equals one hundred eighty percent (180%) of the federal SSI benefit. (7-1-24)

04. Participants with Developmental Disabilities. These allowances are specified in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." PNA for adult participants receiving services under the Developmentally Disabled Waiver is three (3) times the federal SSI benefit amount to an individual in their own home. (7-1-24)

05. Incurred Medical Expenses. Amounts for certain limited medical or remedial services not covered by the participant's Idaho Medicaid Plan and not paid by a third party may be deducted from the base participation amount. The Department must determine whether incurred expenses for such limited services meet the criteria for deduction. The participant must verify such expenses for any to be considered for deduction. Costs for over-the-counter medications are included in the PNA and are not considered a medical expense. Department-approved deductions for necessary medical or remedial expenses are subtracted upon application, and updated when

a participant reports changes to the Department. (7-1-24)

06. Remainder After Calculation. Any remainder after the calculation is the maximum participation amount to be deducted from the participant's provider payments to offset the cost of services. The participation amount is collected from the participant by the provider. The Department notifies the provider and the participant of the amount to be collected. (7-1-24)

07. Recalculation of Participation. The participant's participation amount is recalculated annually at eligibility redetermination or upon verified changes. (7-1-24)

08. Adjustment of Participation Overpayment or Underpayment Amounts. The participant's participation amount is reduced or increased the month following the month of overpayment or underpayment. (7-1-24)

401. -- 999. (RESERVED)