AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 28, 2014

CMS FOIA Officer
Centers for Medicare & Medicaid Services
Mailstop N2-20-16
7500 Security Boulevard
Baltimore, MD 21244

RE: Freedom of Information Act (FOIA) Request pursuant to 5 U.S.C. § 552

Dear CMS FOIA Officer:

Under the Freedom of Information Act, 5 U.S.C. §552, I am requesting access to the following documentation:

1. All emails, memos, letters, notes or correspondence between all Centers for Medicare & Medicaid Services (hereafter "CMS") staff concerning the subject matters raised in the SPA 12-015 SPA Denial issued by CMS to the State of Florida on or about December 13, 2012 (attached hereto and incorporated herein as **Exhibit "A"**).

2. All documents CMS relied upon in formulating the December 13, 2012 Florida SPA 12-015 denial (**Exhibit "A"**).

3. Any Florida policy, codes or regulations relied on by CMS for the contention(s) set forth in the December 13, 2012 denial of Florida SPA 12-015 (**Exhibit "A"**).

4. Any United States Code section, federal policy, federal codes or federal regulation relied on by CMS in issuing its December 13, 2012 denial of Florida SPA 12-015 (**Exhibit "A").**

5. All emails, memos, letters, notes or correspondence between all CMS staff and any other person or entity, including but not limited to any current or former employee of the Florida Hospital Association and/or Florida CHAIN, concerning the subject matters raised in either Florida's SPA 12-015 submission to CMS occurring on or about September 14, 2012, Florida's Request for Reconsideration dated February 7, 2013 (attached hereto and incorporated herein as **Exhibit "B**"), or the SPA 12-015 Denial issued by Ms. Marilyn Tavenner on behalf of CMS on or about December 13, 2012 (**Exhibit "A"**).

6. All emails, memos, letters, notes or correspondence between CMS staff and any other person or entity concerning all state plan coverage limitations involving emergency room service visits caps (such as Florida SPA 12-015, or Idaho State Plan Attachment 3.1-A, p.1, 18 (eff. July 1, 2006)) that CMS has approved or denied.

7. Any and all documentation, including memorandums, email communications, correspondence, notes, records or other documentation, that CMS utilized, review, or relied upon to approve Idaho State Plan Attachment 3.1-A, p.1, 18 (eff. July 1, 2006)) (attached hereto and incorporated herein as **Exhibit "C"**).

8. Any and all documentation, including memorandums, email communications, correspondence, notes, records or other documentation that CMS utilized, reviewed, and/or relied upon in order to issue the February 20, 2014 compliance action Notice issued to the State of Florida (attached hereto and incorporated herein as **Exhibit "D"**).

9. All documents CMS relied upon in formulating the February 20, 2014 compliance action Notice issued to the State of Florida (**Exhibit "D"**).

10. Any Florida policy, codes or regulations relied on by CMS for the contention(s) set forth in the February 20, 2014 compliance action Notice issued to the State of Florida (**Exhibit "D"**).

11. Any United States Code section, federal policy, federal codes or federal regulation relied on by CMS in issuing its February 20, 2014 compliance action Notice issued to the State of Florida (**Exhibit "D"**).

12. All emails, memos, letters, notes or correspondence between all CMS staff and any other person or entity, including but not limited to any current or former employee of the Florida Hospital Association and/or Florida CHAIN, concerning the subject matters raised in the February 20, 2014 compliance action Notice issued to the State of Florida (**Exhibit "D"**).

The information sought should be furnished, pursuant to 5 U.S.C. § 552, without any charge or at a charge reduced below the established fees because the disclosure of the information sought is in the public interest in that it is likely to contribute significantly to public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester.

All information provided will be used by the Agency for Health Care Administration in its capacity as the single state Medicaid agency for the State of Florida and to aid the Agency in development of its State Plan and other policies consistent with federal policy.

I request that the information sough above be provided in electronic format. If you have any questions about handling this request, please do not hesitate to contact me.

Sincerely,

Stuart F. Williams, Esq.
General Counsel
Agency for Health Care Administration
Office of the General Counsel
2727 Mahan Drive, Building 3, MS #3
Tallahassee, FL 32308
Telephone: (850) 412-3630
Fax: (850) 922-6484
Email: Stuart.Williams@ahca.myflorida.com

CC: William Roberts, Esq.
Shena Grantham, Esq.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC 1 3 2012

Justin M. Senior
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive, MS#8
Tallahassee, Florida 32308

Dear Mr. Senior:

I am responding to your request to approve the State of Florida's Medicaid State plan amendment (SPA) 12-015, received by the Centers for Medicare & Medicaid Services (CMS) on September 14, 2012. This amendment reflects a Florida state law that would limit outpatient hospital emergency room visits to six per fiscal year for non-pregnant adults, 21 years of age and older, effective August 1, 2012. For the reasons set forth below, I am unable to approve SPA 12-015 as submitted, because it does not comply with the requirements of section 1902(a)(10) of the Social Security Act (the Act), which incorporates by reference the provisions of 1905(a)(2)(A) of the Social Security Act (the Act) and 42 CFR 440.20(a)(3)(ii).

Under section 1902(a)(10)(A) of the Act, a state plan must provide for making medical assistance available to eligible individuals, including for most eligible individuals the medical assistance specified in section 1905(a)(2) of the Act. This provision includes in the definition of medical assistance "outpatient hospital services." Section 1902(a)(17) of the Act requires the state plan to include reasonable standards for determining the extent of medical assistance, and under section 1902(a)(19) of the Act, the state plan must assure that eligibility for care and services are provided in the best interest of the recipients. As the implementing regulations at 42 CFR 440.230(b) require, a state plan must "specify the **amount, duration, and scope** of each service that it provides," and "each service must be **sufficient** in **amount, duration, and scope** to reasonably achieve its purpose." While states may place "appropriate limits on a service based such criteria as medical necessity or utilization control procedures" under 42 CFR 440.230(d), 42 CFR 440.230(c) specifies that a state may not arbitrarily deny or reduce the amount, duration or scope of required services, including physicians' services, solely because of the diagnosis, type of illness, or ***condition***.

The proposed limitation on certain outpatient hospital services appears to be based on the diagnosis, illness, or condition because it is limited to outpatient services furnished at a hospital emergency room, which are designed to address acute and immediate conditions. Thus, the limitation appears to violate the requirements of 42 CFR 440.230(c). Even if that were not the case, the state has not demonstrated that the limitation is consistent with provision of a sufficient

EXHIBIT A

amount, duration and scope to reasonably achieve the purpose of the benefit, which in this case would be providing reasonable coverage that meets the needs of most beneficiaries who need the outpatient hospital services, consistent with 42 CFR 440.230(b).

While we understand that the state is concerned about inappropriate utilization of hospital emergency rooms, a numeric limitation on services is not an appropriate utilization control method for services that are essential for acute and immediate conditions. My staff suggested to the state some alternative utilization control arrangements to the state, including the development of payment rates for hospital emergency rooms that are lower if the individual does not require care for an acute and immediate condition, or the use of the alternative cost sharing authority available to states under section 1916(d) of the Act permitting higher beneficiary cost sharing for elective non-emergency use of the emergency room. My staff is available to work with the state on these options, and can offer technical assistance.

For these reasons, and after consulting with the Secretary as required by Federal regulations at 42 CFR 430.15(c), I am unable to approve this SPA.

If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of receipt of this letter in accordance with the procedures set forth at 42 CFR 430.18. Your request for reconsideration may be sent to Ms. Cynthia Hentz, Centers for Medicare & Medicaid Services, Center for Medicaid, CHIP and Survey & Certification, 7500 Security Boulevard, Mail Stop S2-26-12, Baltimore, MD 21244-1850.

If you have any questions or wish to discuss this determination further, please contact Ms. Jackie Glaze, Associate Regional Administrator, Division of Medicaid and Children's Health, Centers for Medicare & Medicaid Services, 61 Forsyth Street, Suite 4T20, Atlanta, Georgia 30303-8909.

Sincerely,

Marilyn Tavenner

Marilyn Tavenner
Acting Administrator

cc:

Regional Administrator, Atlanta RO
Associate Regional Administrator, Atlanta RO

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

February 7, 2013

VIA E-MAIL and FED-EX NEXT DAY
Ms. Cynthia Hentz
Centers for Medicare & Medicaid Services
Center for Medicaid, CHIP and Survey & Certification
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Re: Request for Reconsideration of Denial of State Plan Amendment 2012-015

Dear Ms. Hentz:

Pursuant to 42 U.S.C. § 1316(a) and 42 U.S.C. § 1396, et. seq., the Florida Agency for Health Care Administration ("Florida" or "State") requests administrative reconsideration of the denial of the Florida Medicaid State Plan Amendment 2012-015 ("SPA 12-015"), received by the Centers for Medicare & Medicaid Services ("CMS") on September 14, 2012. As discussed below, SPA 12-015 complies with all applicable state and federal laws and Florida should be allowed to amend its state plan accordingly.

I. BACKGROUND

SPA 12-015 was submitted to and received by CMS on September 14, 2012. The SPA reflects a directive provided to the Agency as part of State of Florida House Bill 5001, the General Appropriations Act for State Fiscal Year 2012-2013, to limit outpatient emergency room visits to six per fiscal year for non-pregnant adults that are 21 years of age and older, effective August 1, 2012. The amendment at issue states:

> OUTPATIENT HOSPITAL SERVICES: Pursuant to Florida Statutes, outpatient hospital services are limited to a maximum of $1,500 for non-EPSDT recipients 21 years of age and over per fiscal year. There is no limitation for EPSDT recipients. To best serve the needs of Florida's Medicaid population, the Agency has exempted the following

outpatient hospital services from the $1,500 limitation: emergencies, outpatient surgeries, and life sustaining treatments such as chemotherapy and dialysis.

Emergency room visits for non-pregnant adults, 21 years of age and older, are limited to six visits per fiscal year, effective August 1, 2012. This limit does not apply to aliens.

Per section 409.901(10), F.S., an "emergency medical condition" is defined as:

> (a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
>
> 1. Serious jeopardy to the health of the patient, including a pregnant woman or a fetus.
> 2. Serious impairment to bodily functions.
> 3. Serious dysfunction of any bodily organ or part.
>
> (b) With respect to a pregnant woman:
>
> 1. That there is inadequate time to effect safe transfer to another hospital prior to delivery.
> 2. That a transfer may pose a threat to the health and safety of the patient or fetus.
> 3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

See SPA 12-015, Attachment 3.1-A, pg. 22; Attachment 3.1-B, p. 21.

In its letter dated December 13, 2012, CMS denied Florida's proposed State Plan Amendment 12-015 on the basis that "it does not comply with the requirements of section 1902(a)(10) of the Social Security Act (the Act), which incorporates by reference the provisions of 1905(a)(2)(A) of the Social Security Act (the Act) and 42 C.F.R. §440 20(a)(3)(ii)." The letter identified two deficiencies with regard to SPA 12-015: (1) that the proposed limitation violated 42 C.F.R. §440.230(c) as it appeared to deny coverage based upon a condition since it is "limited to outpatient services furnished at a hospital emergency room, which are designed to address acute and immediate conditions;" and (2) that the proposed limitation did not meet the standards outlined in 42 C.F.R. §440.230(b) as the "state has not demonstrated that the limitation is consistent with provision of a sufficient amount, duration and scope to reasonably achieve the purpose of the benefit, which in this case would be providing reasonable coverage that meets the needs of most beneficiaries who need the outpatient hospital services."

AHCA maintains that SPA 12-015 complies with the above-cited authorities and thus urges CMS to reconsider its denial on those bases. First, the coverage limitation is not a condition-specific limitation and therefore is not barred by federal law. Second, AHCA can demonstrate that SPA 12-015 does provide reasonable coverage to meet the needs of nearly all of the Medicaid recipients who need outpatient hospital services, and therefore does not impermissibly limit the amount, duration or scope of services.

1. SPA 12-015 does not violate the requirements of 42 C.F.R. §440.230(c).

One of CMS's reasons for its denial of SPA 12-015 is the amendment's alleged violation of 42 C.F.R. §440.230(c), stating as follows: "(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition." See 42 C.F.R. §440.230(c); see also 42 C.F.R. §440.220(a)(1). CMS contends that the outpatient hospital visit coverage limitation limiting a non-pregnant recipient to six visits per fiscal year violates the federal rule because it places a limit upon hospital services furnished in a hospital emergency room, which are designed to address acute and immediate conditions.

However, this view is not supported by a plain reading of the proposed coverage limitation. SPA 12-015 does not arbitrarily deny or reduce coverage on the sole basis of a Medicaid recipients' diagnosis, illness type, or condition in capping the amount of visits that a Medicaid recipient can receive; rather, all non-pregnant citizens over the age of twenty-one are treated identically under this state plan amendment regardless of their condition, illness, or diagnosis. The limitation is lawfully directed towards the venue in which a service is rendered, which does not necessarily characterize the type of service that is performed.

It is worth noting that AHCA has lessened the impact of the six visit cap by allowing for several exemptions to its application. The coverage limitation specifically exempts pregnant women, children under the age of twenty-one, and undocumented aliens. Additionally, Florida has built in multiple safeguards even for those recipients who have reached their six visit annual limit. To the extent that a Medicaid recipient presents to the emergency room with a condition leading the hospital to admit them as an inpatient, the recipient's services will not be counted

towards the six visit limitation. Medicaid recipients may also choose to receive services at any time through a federally qualified health center ("FQHC"), as the SPA 12-015 coverage limitation does not apply to these facilities.[1] Thus, under SPA 12-015, Medicaid recipients are still able to seek and receive treatment for any illness, diagnosis or condition. In proposing the Amendment, Florida is simply attempting to create a more efficient system in which recipients are diverted to the most appropriate and cost effective forum in which to receive services without limiting access to quality health care.

A venue-specific coverage limitation of the type set forth in SPA 12-015 is valid under federal law as an appropriate safeguard against the unnecessary utilization of services. Participating states are not required to fund all medical services falling under one of the mandatory coverage categories. Beal v. Doe, 432 U.S. 438, 443 (1977). Rather, Title XIX "confers broad discretion on the States to adopt standards for determining the extent of medical assistance" offered in their Medicaid programs. Id. at 444. Assuming that a plan meets federal requirements, a state has considerable discretion in administering its Medicaid program. See Fla. Ass'n of Rehab. Facilities, Inc. v. Fla. Dep't of Health & Rehab. Servs., 225 F.3d 1208, 1211 (11th Cir. 2000), relied upon in Moore ex rel. Moore v. Reese, 637 F.3D 1220, 1238 (11th Cir. 2011). Thus, federal Medicaid law expressly permits participating states to "place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures," and requires states to implement "such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan *as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care.*" See 42 C.F.R. § 440.230(d); 42 U.S.C. § 1396a(a)(30)(A) (emphasis added).

Moreover, CMS' objection that SPA 12-015 violates 42 C.F.R. § 440.230(c) because it limits the amount of services provided in hospital emergency rooms, and because hospital emergency room provide acute and immediate conditions it consequently limits the amount of

[1] Beginning December 6, 2012, the policy limits for FQHC have increased to allow up to three encounters (medical, dental, and mental health visits) per recipient, per day.

services based on a condition ignores a fundamental aspect of the rule. As clearly and unambiguously stated in 42 C.F.R. § 440.230(c): "The Medicaid agency may not **arbitrarily** deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary **solely** because of the diagnosis, type of illness, or condition." Thus, the rule does not prohibit states from exercising their discretion to limit the amount of services based on condition; rather, the rule only prohibits states from **arbitrarily** reducing the amount of a service **solely** on the basis of condition. See, e.g., Charleston Memorial Hosp. v. Conrad, 693 F.2d 324 (4th Cir. 1982) (Court upheld state plan amendment where state was not seeking to "escape compliance with statutory or regulatory requirements" but instead "reduced inpatient and outpatient hospital coverage to a level that is fiscally feasible but still satisfies federal requirements"); see also Curtis v. Taylor, 625 F.2d 645, 653 (5th Cir.1980), modified, 648 F.2d 946 (5th Cir. 1980); Virginia Hospital Ass'n v. Kenley, 427 F. Supp. 781, 786 (E.D. Va. 1977). Thus, even if SPA 12-015 has the unintended consequence of potentially limiting the services relating to persons with an "acute" or "emergency" condition, the SPA was not submitted for that basis, let alone solely for that basis. Nor was the purpose of the SPA arbitrary. Instead, as discussed above, Florida has chosen this venue-specific coverage limitation as a lawful mechanism it can utilize in order to ensure that Medicaid payments are consistent with efficiency, economy, and quality of care.

Finally, CMS has previously indicated its approval of this limitation in at least one other state. Idaho's State Plan limits outpatient hospital services as follows:

> "2.a. Outpatient Hospital Services Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment. Refer to items 3.1-A-i and 5 for excluded services and information concerning abortion services.
>
> Limitations: Emergency room services are limited to six (6) visits per calendar year. Those services, however, which are followed immediately by admission on an inpatient status, will be excluded from the above limitation."

See Idaho State Plan, Attachment 3.1-A, pg. 1, 18 (eff. July 1, 2006).

The Idaho State Plan coverage limitation cited above largely mirrors Florida's SPA 12-015. In fact, Idaho's provision is more restrictive in its application in that it does not provide for an

exemption for undocumented aliens or pregnant women. It is unclear why CMS would deem Idaho's state plan permissible for the past 6.5 years, yet simultaneously deem Florida's less restrictive proposed plan to be impermissible; such a ruling would appear to be arbitrary and therefore impermissible. See 5 U.S.C. § 706(2)(A).

In sum, SPA 12-015 does not arbitrarily reduce coverage on the sole basis of a Medicaid recipients' diagnosis, illness type, or condition. Rather, it is a valid venue-specific limitation put in place to safeguard against the unnecessary utilization of services in a forum that is extremely costly to taxpayers, i.e., emergency rooms, instead of less costly and appropriate alternatives to treatment venues such as a physician's office or FQHC. Because SPA 12-015 does not reduce coverage on the basis of a Medicaid recipients' diagnosis, illness type, or condition, AHCA respectfully requests that CMS reconsider its denial on this basis.

2. SPA 12-015 does not impair the State of Florida's ability to provide reasonable coverage that meets the needs of most beneficiaries who need outpatient hospital services, consistent with 42 CFR 440.230(b).

The second deficiency identified by CMS with regard to SPA 12-015 is that the proposed limitation does not meet the standards outlined in 42 C.F.R. §440.230(b) as the "state has not demonstrated that the limitation is consistent with provision of a sufficient amount, duration and scope to reasonably achieve the purpose of the benefit, which in this case would be providing reasonable coverage that meets the needs of most beneficiaries who need the outpatient hospital services." However, this is not accurate as Florida is able to demonstrate that SPA 12-015 does not impede the state's ability to meet the coverage needs of the vast majority of Medicaid beneficiaries who require such services.

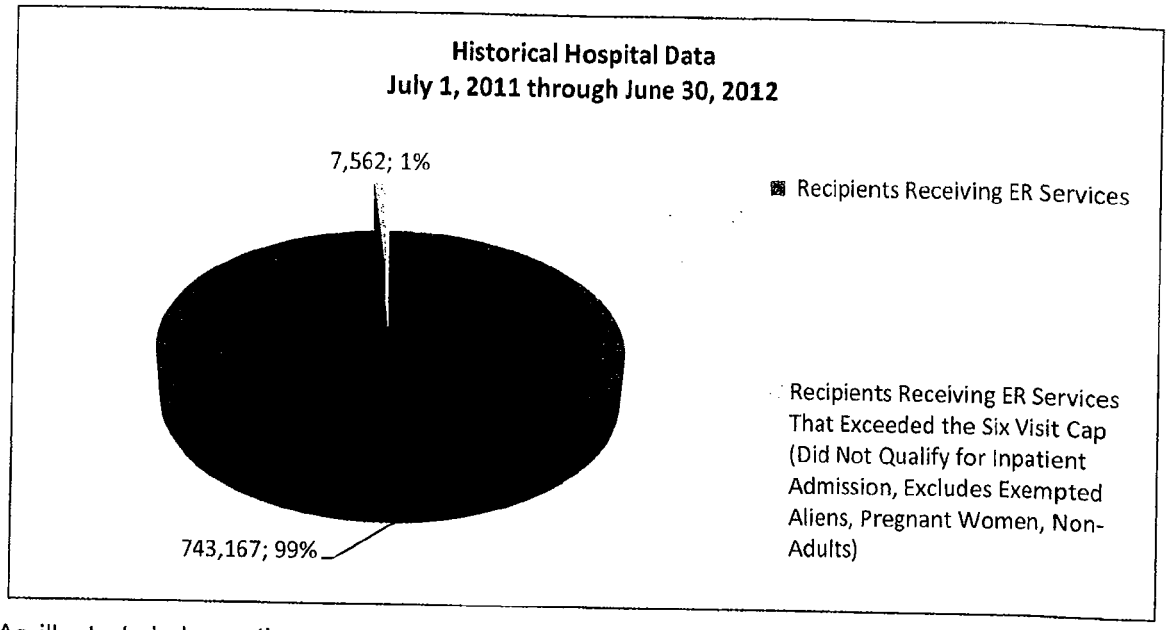
A service is "sufficient in amount, duration, and scope" under 42 C.F.R. § 440.230(b) if it is "adequate to service the needs of most of the individuals eligible for Medicaid assistance." See Curtis v. Taylor, 625 F.2d 645, 653 (5th Cir.1980), modified, 648 F.2d 946 (5th Cir. 1980) (reduction in coverage of physician visits to three per month upheld where the needs of 96.1% of the Medicaid population were met by the coverage); Virginia Hospital Ass'n v. Kenley, 427 F. Supp. 781, 786 (E.D. Va. 1977) (upholding reduction in physician visits coverage to 21 days;

21-day limit would meet needs of 92% of Medicaid population); Charleston Memorial Hosp. v. Conrad, 693 F.2d 324 (4th Cir. 1982) (upholding reduction in both inpatient hospital coverage, where the limit would meet the needs of 88% of Medicaid recipients requiring such care, and a limit on outpatient hospital coverage, where the limit would meet the needs of 99% of Medicaid recipients requiring such care).

AHCA maintains that the service coverage limitation proposed is consistent with the standards outlined in 42 C.F.R. §440.230(b). As previously stated, there are multiple safeguards in to the amendment that protect vulnerable classes of Medicaid recipients who may require more than six emergency room visits per year, such as: pregnant women, recipients under the age of twenty-one, aliens, and those who are subsequently admitted as an inpatient as a result of presenting in the emergency room. Additionally, recipients may seek care from FQHCs across the state.

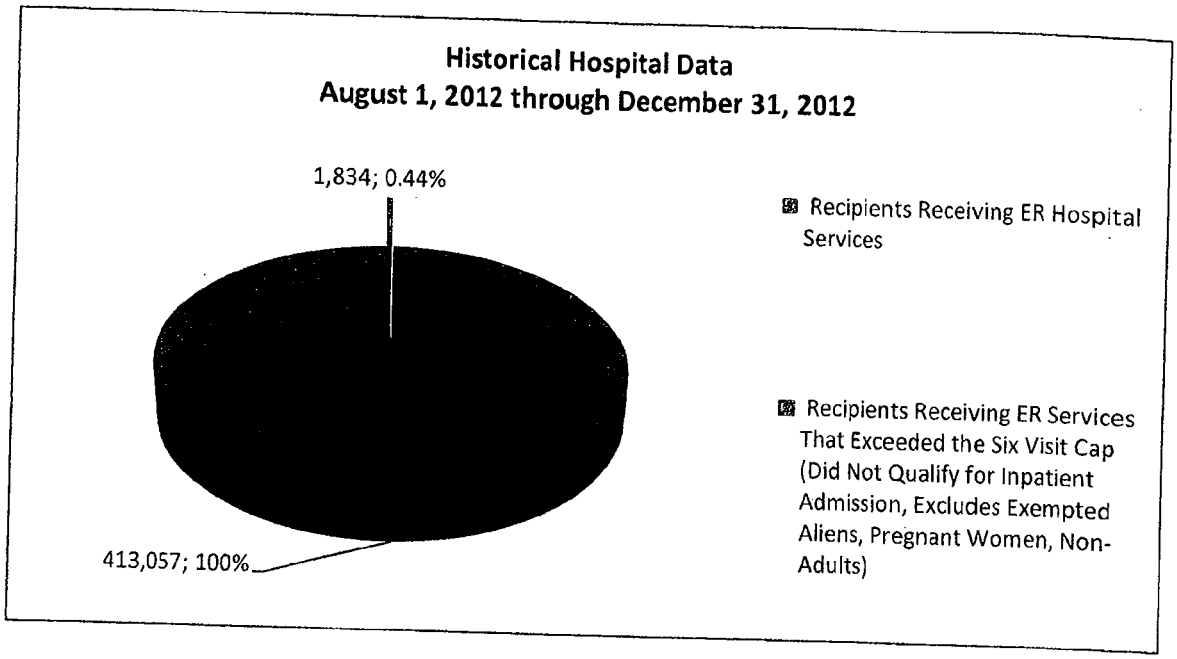
Taking this into account, AHCA reiterates that SPA 12-015 poses a strikingly negligible impact on the Florida Medicaid population. The table below illustrates the impact as applied to historical data for Fiscal Year 2011 ("FY 2011")[2].

[2] AHCA would like to point out at this time that in its September 14, 2012 correspondence enclosing the state plan amendment at issue, the Agency stated it was providing historical claims data from state fiscal year 2010-2011 in which it identified 272,445 recipients who received emergency room care. However, upon review, the data referred to was in fact from fiscal year 2009-2010.



As illustrated above, the proposed coverage limitation would have affected only one percent of all Medicaid recipients who sought services at an emergency room for FY 2011. Thus, for this fiscal year, the coverage would have been "sufficient in amount, duration, and scope" to meet the needs of 99% of all Medicaid recipients seeking emergency room services, in keeping with 42 C.F.R. §440.230(b).

Since SPA 12-015 was implemented on August 1, 2012 pursuant to the Appropriations Act, AHCA is in a position to confirm that the impact is as *de minimus* as the data from previous years had predicted. The table below illustrates the impact as applied to claims data for August 1, 2012 through December 31, 2012.



The coverage limitation had an actual effect on less than one percent (i.e. 0.44%) of all Medicaid recipients who sought outpatient hospital services at the emergency room during the six month period following the implementation of SPA 12-015. Federal courts have ruled that even a coverage limitation which impacts 12% of Medicaid recipients, in comparison to the less than 1% at issue here, is valid under 42 C.F.R. §440.230(b) in light of its *de minimis* impact on the overwhelming majority of the Medicaid population. See, e.g., Charleston Memorial Hosp. v. Conrad, 693 F.2d 324 (4th Cir. 1982) (upholding reduction in both inpatient hospital coverage, where the limit would meet the needs of 88% of Medicaid recipients requiring such care, and outpatient hospital coverage, where the limit would meet the needs of 99% of Medicaid recipients requiring such care).

Further, AHCA anticipates that the impact upon recipients will only get smaller. Florida is currently in the midst of its transition into a managed care model of health care. To those recipients covered under the managed care model, scheduled to complete in October of 2014, this coverage limitation will have no effect.

II. CONCLUSION

In sum, for the foregoing reasons, AHCA respectfully requests that CMS reconsider its denial of SPA 12-015. AHCA has demonstrated that this venue-specific coverage limitation is authorized under federal law in light of relevant case law and CMS's historical acceptance of an even more rigorous outpatient hospital coverage limitation. Additionally, AHCA has demonstrated that this state plan amendment currently affects one percent or less of the affected Medicaid population. AHCA anticipates this number will only decrease as the state transitions into a managed care model. Thus, AHCA maintains that SPA 12-015 does not impair the State of Florida's ability to provide reasonable coverage that meets the needs of most beneficiaries who need outpatient hospital services, consistent with 42 C.F.R. §440.230.

Please let me know if you have further questions or if it would help to have our respective staff confer on this issue. Finally, I would appreciate it if you could direct a copy of all future correspondence relating to this matter to:

Stuart F. Williams, Esq.
General Counsel
Agency for Health Care Administration
Office of the General Counsel
2727 Mahan Drive, Building 3, MS #3
Tallahassee, FL 32308
Telephone: (850) 412-3630
Email: Stuart.Williams@ahca.myflorida.com

We appreciate your attention to this matter and look forward to working with you further to resolve it.

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

CC:

Stuart F. Williams, Esq.
Shena L. Grantham, Esq.
Ms. Jackie Glaze, Associate Regional Director

FedEx Express Package US Airbill

FedEx Tracking Number 8019 6990 5263

Form ID No. 0215

SPH1

From *Please print and press hard.*

Date 9/17/13 Sender's FedEx Account Number 4509-1250-6

Sender's Name Justin Scanlon Phone (850) 414-4[illegible]

Company AGENCY FOR HEALTH CARE ADMIN

Address 2727 MAHAN DR BLDG 2 Dept./Floor/Suite/Room

City TALLAHASSEE State FL ZIP 32308-5407

Your Internal Billing Reference First 24 characters will appear on invoice. [illegible]

To

Recipient's Name Cynthia Heintz Phone ( )

Company CMS/Center for Medicaid & Chip Svcs

Address 7500 Security Blvd Dept./Floor/Suite/Room

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0102181102

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- [ ] FedEx Priority Overnight — Next business morning.* Friday shipments will be delivered on Monday unless SATURDAY Delivery is selected.
- [x] FedEx Standard Overnight — Next business afternoon.* Saturday Delivery NOT available.
- [ ] FedEx 2Day A.M. — Second business morning.* Saturday Delivery NOT available.
- [ ] FedEx 2Day — Second business afternoon.* Thursday shipments will be delivered on Monday unless SATURDAY Delivery is selected.
- [ ] FedEx Express Saver — Third business day.* Saturday Delivery NOT available.

5 Packaging • Declared value limit $500.

- [ ] FedEx Envelope*
- [ ] FedEx Pak*
- [ ] FedEx Box
- [ ] FedEx Tube
- [ ] Other

6 Special Handling and Delivery Signature Options

- [ ] SATURDAY Delivery — NOT available for FedEx Standard Overnight, FedEx 2Day A.M., or FedEx Express Saver.

- [ ] No Signature Required — Package may be left without obtaining a signature for delivery.
- [ ] Direct Signature — Someone at recipient's address may sign for delivery. *Fee applies.*
- [ ] Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. For residential deliveries only. *Fee applies.*

Does this shipment contain dangerous goods? One box must be checked.

- [ ] No
- [ ] Yes — As per attached Shipper's Declaration.
- [ ] Yes — Shipper's Declaration not required.
- [ ] Dry Ice — Dry Ice, 9, UN 1845 ____ x ____ kg

Dangerous goods (including dry ice) cannot be shipped in FedEx packaging or placed in a FedEx Express Drop Box.

- [ ] Cargo Aircraft Only

7 Payment *Bill to:* Enter FedEx Acct. No. or Credit Card No. below.

- [ ] Sender — Acct. No. in Section 1 will be billed.
- [ ] Recipient
- [ ] Third Party
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FedEx Acct. No. / Credit Card No. Exp. Date

Total Packages Total Weight Total Declared Value†

____ ____ lbs. $ ____ .00

†Our liability is limited to US$100 unless you declare a higher value. See back for details. By using this Airbill you agree to the service conditions on the back of this Airbill and in the current FedEx Service Guide, including terms that limit our liability.

611

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Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991
0MB No.: 0938-

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: / / No limitations / X / With limitations*

2.a. Outpatient hospital services.

   Provided: / / No limitations / X / With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the State Plan.

   / X / Provided: / / No limitations / X / With limitations*

   / / Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   / X / Provided: / / No limitations / X / With limitations*

3. Other laboratory and x-ray services.

   Provided: / / No limitations / X / With limitations*

*Description provided on attachment.

EXHIBIT C

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: / / No limitations /X/ With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child—bearing age.

Provided: / / No limitations /X/ With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: / / No limitations /X/ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: / / No limitations /X/ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: / / No limitations / / With limitations*

/ X / Not Provided

* Description provided on attachment.

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

c. Chiropractors' services.

/ / Provided: / / No limitations / / With limitations*

/X / Not provided.

d. Other practitioners' services.

/ X / Provided:

/ / Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: / / No limitations /X / With limitations*

/ / Not Provided

b. Home health aide services provided by a home health agency.

Provided: / / No limitations /X / With limitations*

/ / Not Provided

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: / / No limitations / X/With limitations*

/ / Not Provided

*Description provided on attachment.

9. Clinic services.

// Provided: / / No limitations // With limitations*

/ X / Not provided.

10. Dental services.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/ / Provided: / / No limitations / / With limitations

/ X / Not provided.

b. Occupational therapy.

/ / Provided: / / No limitations / / With limitations*

/ X/ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

*Description provided on attachment.

IDAHO MEDICAID
STANDARD STATE PLAN

Revision: HCFA—PM—85—3 (BERC) Attachment 3.1-A

May 1985 OMB No: 0938-0193

State: IDAHO

Attachment 3.1-A - AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/ / Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Dentures.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

c. Prosthetic devices.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

d. Eyeglasses.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

*Description provided on Attachment 3.1-A page 5a.

Attachment 3.1-A - AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12.a **Prescribed Drugs for Tobacco Cessation.**

The Department will cover tobacco cessation drug products for pregnant women when prescribed by their physician.

The following products are covered:

- Chantix tablets
- Nicotine gum, all strengths
- Nicotine lozenges, all strengths
- Nicotine patches, all strengths
- Nicotine Nasal Spray, all strengths

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

c. Preventive services.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

d. Rehabilitative services.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

b. Skilled nursing facility services.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

c. Intermediate care facility services.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

/ Provided: / / No limitations / With limitations*

/ X / Not provided.

17. Nurse—midwife services.

/ X / Provided: / / No limitations / X / With limitations*

/ / Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OP MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1—A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

// Provided: // With limitations

/ X / Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

/ / Provided: / / With limitations*

/ X / Not provided.

20. Extended services for pregnant women

a. Pregnancy—related and postpartum services for a 60—day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

// Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

// Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

23. Certified pediatric or family nurse practitioners' services.

Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: / / No limitations / X / With limitations*

/ / Not provided.

b. Services of Christian Science nurses.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

c. Care and services provided in Christian Science sanitaria.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

d. Nursing facility services for patients under 21 years of age.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

e. Emergency hospital services.

/ X / Provided: / / No limitations / X / With limitations*

/ / Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/ / Provided: / / No limitations / / With limitations*

/ X / Not provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: Idaho

SECTION 3 – SERVICES: GENERAL PROVISIONS

3.1 **Amount, Duration, and Scope of Services**

Medicaid is provided in accordance with the requirements of sections 1902(a), 1902(e), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929, and 1933 of the Act; section 245A(h) of the Immigration and Nationality Act; and 42 CFR Parts 431, 440, 441, 442, and 483.

A. **Categorically Needy**

28. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary in accordance with section 1905(a)(28) of the Social Security Act and 42 CFR 440.170.

a. Transportation (provided in accordance with 42 CFR 440.170) as an optional medical service) excluding "school-based" transportation.

☐ Not Provided:

☐ Provided without a broker as an optional medical service:

(**If** state attests "Provided without a broker as an optional medical service" **then insert** supplemental information.)

Describe below how the transportation program operates including types of transportation and transportation related services provided and any limitations. Describe emergency and non-emergency transportation services separately. Include any interagency or cooperative agreements with other Agencies or programs.

X Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4).

(**If** the State attests that non-emergency transportation is being provided through a brokerage program **then insert** information about the brokerage program.)

Medicaid has contracted with American Medical Response (AMR) to provide non-emergent transportation services. Medicaid pays AMR a per participant per month (PPPM) amount for each eligible Medicaid participant to cover their non-emergency transportation needs. These services are provided under a brokerage model which requires AMR to coordinate all services statewide.

Medicaid's brokerage arrangement shifts trip scheduling from being driven primarily by transportation providers to a process that is driven by the Medicaid participant's needs. The brokerage arrangement allows for greater efficiency in assigning trips and allocating transportation resources:

The shift to a brokerage is expected to save Idaho Medicaid a minimum of $500,000 annually as compared to past yearly expenses for this service. $100,000 of that amount comes from state general funds at current federal matching levels.

X The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(i).

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

☐ (1) state-wideness (indicate areas of State that are covered)

☐ (10)(B) comparability (indicate participating beneficiary groups)

X (23) freedom of choice (indicate mandatory population groups) for all groups

(2) Transportation services provided will include:

X wheelchair van

X taxi

X stretcher car

X bus passes

X tickets

X secured transportation

X☐ other transportation (if checked describe below other transportation.)

Passenger vehicle

(3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs:

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed qualified, competent and courteous:

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services:

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.)

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

X Low-income families with children (section 1931)

X Deemed AFCD-related eligibles

X Poverty-level related pregnant women

X Poverty-level infants

X Poverty-level children 1 through 5

X Poverty-level children 6 – 18

X Qualified pregnant women AFDC – related

X Qualified children AFDC – related

X IV-E foster care and adoption assistance children

X TMA recipients (due to employment) (section 1925)

X TMA recipients (due to child support)

X SSI recipients

(5) The broker contract will provide transportation to the following categorically needy optional populations:

X Optional poverty-level - related pregnant women

X Optional poverty-level - related infants

X Optional targeted low income children

☐ Non IV-E children who are under State adoption assistance agreements

☐ Non IV-E independent foster care adolescents who were in foster care on their 18th birthday

X Individuals who meet income and resource requirements of AFDC or SSI

☐ Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency

☐ Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law

☐ Children aged 15-20 who meet AFDC income and resource requirements

☐ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution

☐ Individuals infected with TB

X Individuals screened for breast or cervical cancer by CDC program

☐ Individuals receiving COBRA continuation benefits

☐ Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard

X Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution

X Individuals terminally ill if in a medical institution and will receive hospice Care

X Individuals aged or disabled with income not above 100% FPL

☐ Individuals receiving only an optional State supplement in a 209(b) State

X Individuals working disabled who buy into Medicaid (BBA working disabled group)

☐ Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group

X Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids).

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:

X (i) risk capitation

☐ (ii) non-risk capitation

☐ (iii) other (e.g., brokerage fee and direct payment to providers) (If checked describe any other payment methodology)

(B) Who will pay the transportation provider?

X (i) Broker

☐ (ii) State

☐ (iii) Other (if checked describe who will pay the transportation provider)

(C) What is the source of the non-Federal share of the transportation payments? Describe below the source of the non-Federal share of the transportation payments proposed under the State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payment, please separately identify each source of non-Federal share funding. State funds.

X (D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

☐ (E)The State assures that payments proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

X (7) The broker is a non-governmental entity:

X The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial

relationship as described at 42 CFR 440.170(4)(ii).

☐ The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

☐ Transportation is provided in a rural area as defined at 42 CFR 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

☐ Transportation is so specialized that there is no other available Medicaid participating provider Or other provider determined by the State to be qualified except the non-governmental broker.

☐ The availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

☐ (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with Another governmental entity for transportation. The governmental broker will:

☐ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

☐ Document that with respect to each individual beneficiary's specific transportation needs, the government provider is the most appropriate and lowest cost alternative.

☐ Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public para-transit services than the rate charged to other State human services agencies for the same service.

(9) Please describe below how the NEMT brokerage program operates. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

AMR operates a call center which receives requests from participants for transportation. AMR verifies participant eligibility and need for transportation services. AMR then schedules trips within its contracted transportation provider network.

AMR is prohibited from providing direct transportation services and does not compete with these providers.

AMR monitors the quality of service delivered by these providers and the safety of their vehicles.

AMR is paid a per member per month (PPPM) amount for each eligible participant to cover their claims administration costs, call center, payment to the transportation providers, and other operations required in the contract.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

g. Primary Care Case Management

/ / Not provided

/ X / Provided

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Su 2 to Attachment 3.1-A, and Appendices A—G to Supplement 2 to Attachment 3.1—A.

/ / provided /X/ not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

// Provided: / / State Approved (Not Physician) Service Plan Allowed
/ / Services Outside the Home Also Allowed
// Limitations Described on Attachment

/ X / Not Provided.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Attachment 3.1-A

Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☐ No limitations ☐ With limitations X None licensed or approved

Please describe any limitations:

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☐ No limitations ☐ With limitations (please describe below)

X Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

☐ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

3.1-A Amount, duration and scope of medical and remedial care and services provided:

1. Inpatient Hospital Services: No limitation is placed on the number of inpatient hospital days. However, such inpatient services must be medically necessary as determined by the Department or its authorized agent. Payment is limited to semiprivate room accommodations unless private accommodations are medically necessary and ordered by the physician.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Excluded Services:

- Elective medical and surgical treatments, except family planning services, without Department approval.
- Non-medically necessary cosmetic surgery
- New procedures of unproven value and established procedures of questionable current usefulness that are excluded by Medicare program and other commercial carriers. Questionable procedures are reviewed using the criteria listed in IDAPA 16.03.09.443.
- Surgical procedures for the treatment of morbid obesity and panniculectomies unless medically necessary for a co-morbid condition.
- Acupuncture, biofeedback therapy, and laetrile therapy Procedures, counseling, and testing for the inducement of fertility
- All transplants
- Treatment of complications, consequences, or repair of any medical procedure in which the original procedure was excluded from Medicaid, unless determined to be medically necessary by the Department or its designee
- Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21)

Limitations:

- Abortion Services - the Department will only fund abortions to save the life of the mother or in cases of rape or incest as determined by the courts. Two licensed physicians must certify in writing that the mother may die if the fetus is carried to term. This certification must contain the name and address of the recipient.

2. a. Outpatient Hospital Services Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment. Refer to items 3.1-A-i and 5 for excluded services and information concerning abortion services.

Limitations:

- Emergency room services are limited to six (6) visits per calendar year. Those services, however, which are followed immediately by admission on an inpatient status, will be excluded from the above limitation.

b. Rural Health Clinics Services provided by nurse practitioners are limited to their scope of practice as defined in Section 54-1402(d) of Idaho Code. Services provided by physician assistants are limited to their scope of practice as defined in Section 54-1803(11) of the Idaho Code.

c. Federally Qualified Health Centers Federally qualified health centers provided within the scope, amount, and duration of the State's medical assistance program as described under Subsection 16.03.09.830-835 of the state of Idaho's Rules Governing Medical Assistance.

3. Other Laboratory and X-ray Services: Other laboratory and x-ray services are provided upon and under the direction of a physician or other licensed practitioner.

Excluded Services:

- Laboratory and/or x-ray procedures which are associated with excluded services found in Sections 3.1-A.1 and 3.1-A.5 of this plan are excluded from payment.

4. a. Nursing Facility Care Services: must have prepayment approval before payment is made. Such authorization is initiated by the Long Term Care Unit who secures a determination of medical entitlement from the Regional Medicaid Services Unit.

b. Health Check - Early Periodic Screening, Diagnosis and Treatment (EPSDT).

Services under EPSDT are available to all Medicaid recipients up to and including the month of their twenty-first (21st) birthday.

Screening: EPSDT services include the screening, immunization, vision, hearing and dental services as recommended by the American Academy of Pediatrics periodicity schedule.

EPSDT services also include diagnosis and treatment involving medical care within the scope of the Idaho State Plan and such other necessary health care described in Section 1905(a) of the Social Security Act, and not included in the Idaho Title XIX State Plan as required to correct or ameliorate defects and physical and mental illness discovered by the screening service. The Department will set amount, duration and scope for services provided under EPSDT. Needs for services discovered during an EPSDT screening which are outside the coverage provided by the Rules Governing Medical Assistance must be shown to be medically necessary to correct or improve the physical or mental illness discovered by the screening, ordered by the physician, nurse practitioner or physician's assistant and authorized by the Department.

Limitations

- The Department will not cover services that are not medically necessary.
- Any service identified as a result of an EPSDT screen, covered under Title XIX of the Social Security Act, and currently covered under the scope of the Idaho Medicaid program will not be subject to the existing amount, scope, and duration limitations, but will be subject to prior authorization. The additional service(s) must be documented by the attending physician as to why the service is medically necessary.
- Any service identified as a result of an EPSDT screen that is not covered or beyond the scope of coverage under section 3.1-A will require review for medical necessity and must be prior authorized prior to payment. The additional service(s) must be documented by the attending physician as to why the service is medically necessary.

4. c. Family Planning Services and Supplies for Persons of Child Bearing Age

The Department will provide family planning services which include:

- Counseling and medical services prescribed by a licensed physician, qualified certified nurse practitioner, or physician's assistant. The Department will cover diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization.
- Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives, which are limited to purchase of a three-month supply at a time.
- Sterilization procedures are limited to persons who are at least twenty-one (21) years of age or older at the time of signing the informed consent form. A person over the age of 21 that is incapable of giving informed consent will be ineligible to receive Medicaid payment for the sterilization. The person must voluntarily sign the informed consent form at least thirty (30) days, but not more than 180 days, prior to the sterilization procedure. Sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are ineligible unless ordered by the court of law. Hysterectomies performed solely for sterilization are ineligible for Medicaid payment.

Attachment 3.1-A Program Description

4. d. Tobacco Cessation Counseling Services for Pregnant Women

1) Face-to-Face Counseling Services provided:

[X] (i) By or under supervision of a physician

[X] (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or

[_] (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (none are designated at this time)

2) Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women

Provided: [X] No limitations [_] With limitations*

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period should be explained below.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department, as required.

5. a. Physician Services. The Department will reimburse for treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and in accordance to the restrictions and exclusions of coverage contained in Idaho Department of Health and Welfare Rules and Regulations.

Excluded Services:

- Elective medical and surgical treatments, except family planning services are excluded from Medicaid payment without prior approval by the Department.
- New procedures of unproven value and established procedures of questionable current usefulness that are excluded by Medicare program and other commercial carriers. Questionable procedures are reviewed using the criteria listed in IDAPA 16.03.09.443.
- Non-medically necessary cosmetic surgery
- Surgical procedures for the treatment of morbid obesity and panniculectomies unless medically necessary for co-morbid conditions.
- Acupuncture services, naturopathic services, biofeedback therapy, laetrile therapy, and eye exercise therapy
- Procedures, counseling, office exams and testing for the inducement of fertility
- All transplants
- Drugs
- The treatment of complications, consequences, or repair of any medical procedure in which the original procedure was excluded from Medicaid, unless medically necessary as determined by the Department or it's designee
- Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21)

5. a. Physician Services (cont.)

Limitations:

- Payment for tonometry is limited to two (2) exams for individuals over the age of forty (40) during any twelve (12) month period (either separately or as part of a vision exam). Individuals with a diagnosis of Glaucoma are excluded from this limitation.
- Abortion Services - The Department will only fund abortions to save the life of the mother or in cases of rape or incest as determined by the courts. Two licensed physicians must certify in writing that the mother may die if the fetus is carried to term. This certification must contain the name and address of the recipient

5.

b. Medical and Surgical Furnished by a Dentist: The Department will reimburse for treatment of medical and surgical dental conditions by a licensed dentist subject to the limitations of practice imposed by state law, and according to the restrictions and exclusions of coverage contained in Rules Governing Medical Assistance, IDAPA 16.03.09.900 through 915.

Dentist Limitations: Elective medical and surgical dental services are excluded from Medicaid payment unless prior approved by the Department. All hospitalizations for dental care must be prior approved by the Department. Non medically necessary cosmetic services are excluded from Medicaid payment. Drugs supplied to patients for self-administration other than those allowed under Rules Governing Medical Assistance, IDAPA 16.03.09.805 through 818 are excluded from Medicaid payment.

6.

d. Services under Other Practitioners: Includes those services provided by a nurse practitioner and physician assistant as defined by state and federal law. This coverage has the same exclusions as listed in Attachment 3.1.A Program Description 5.a. Physician Services.

Attachment 3.1-A Program Description

(6.d continued)

Licensed Midwife (LM)

Licensed Midwife services include maternal and newborn care provided by LM providers within the scope of their practice. Medicaid will reimburse LM providers for antepartem, intrapartum, up to six (6) weeks of postpartum maternity care, and up to six weeks of newborn care.

17. Certified Nurse Midwife Services

Those services provided by certified nurse midwives as defined by state and federal law. This coverage has the same exclusions as listed in Attachment 3.1-A Program Description 5.a Physician Services

21. Ambulatory Prenatal Care for Pregnant Women During a Presumptive Eligibility Period by an eligible provider (in accordance with section 1920 of the Act).

During the presumptive eligibility period, outpatient services related to pregnancy and complication thereof are covered. Extended services are not covered under the presumptive eligibility period.

23. Certified Pediatric or Family Nurse Practitioners' Services

Those services provided by certified pediatric or family nurse practitioners as defined by state and federal law. This coverage has the same exclusions as listed in Attachment 3.1-A Program Description 5.a. Physician Services. This coverage specifically includes services by certified pediatric and family nurse practitioners as required by Section 1905(a) (21) of the Act.

24. a. Transportation. Transportation services and assistance for eligible persons to covered medical services in the form of "necessary" transportation is provided. Transportation to services for the performance of medical services or procedures which are excluded from 3.1-A Program Description is excluded from transportation reimbursement. Transportation to services authorized under EPSDT is covered.

e. Emergency Hospital Services. Emergency room services are limited to six (6) visits per calendar year. Those services, however, which are followed immediately by admission on an inpatient status, will be excluded from the above limitation.

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IDAHO MEDICAID
STANDARD STATE PLAN

Supplement 1 to Attachment 3.1-A, Program Description

1915(i) STATE PLAN HOME AND COMMUNITY-BASED SERVICES
A. Children with Developmental Disabilities

1915(i) State plan Home and Community-Based Services
Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. Services. *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Respite
Habilitative Supports
Family Education
Community Support Services
Support Broker
Financial Management Services

2. Statewideness. *(Select one):*

X	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one):*

X	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:	
	○ The Medical Assistance Unit *(name of unit)*:	
	X Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	Division of Family and Community Services, Department of Health and Welfare
○	The State plan HCBS benefit is operated by *(name of agency)*	
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

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STANDARD STATE PLAN

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Distribution of State plan HCBS Operational and Administrative Functions.

☒ *(By checking this box the State assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 State plan HCBS enrollment managed against approved limits, if any .	☐	☐	☐	☐
3 Eligibility evaluation	☑	☐	☑	☐
4 Review of participant service plans	☑	☐	☐	☐
5 Prior authorization of State plan HCBS	☑	☐	☐	☐
6 Utilization management	☑	☐	☐	☐
7 Qualified provider enrollment	☑	☐	☐	☐
8 Execution of Medicaid provider agreement	☑	☐	☐	☐
9 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit.	☑	☐	☐	☐
11 Quality assurance and quality improvement activities	☑	☐	☐	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Eligibility evaluation: Independent Assessment Provider

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(By checking the following boxes the State assures that):

5. [X] **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

   N/A

6. [X] **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. [X] **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. [X] **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

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Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of
Year 1	July 1, 2011	June 30, 2012	3,195
Year 2	July 1, 2012	June 30, 2013	3,387
Year 3	July 1, 2013	June 30, 2014	3,590
Year 4	July 1, 2014	June 30, 2015	3,805
Year 5	July 1, 2015	June 30, 2016	4,033

2. [X] **Annual Reporting.** *(By checking this box the State agrees to)*: annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

3. **Optional Annual Limit on Number Served.**

[X]	The State does not limit the number of individuals served during the year.

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Financial Eligibility

1. [X] **Income Limits.** *(By checking this box the State assures that)*: Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2. Medically Needy. *(Select one):*

[X]	The State does not provide State plan HCBS to the medically needy.
[ ]	The State provides State plan HCBS to the medically needy *(select one)*:
[ ]	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
[ ]	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual. Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*select one*):

[ ]	Directly by the Medicaid agency
[X]	By Other (*specify State agency or entity with contract with the State Medicaid agency*):
	Contracted Independent Assessment provider(s) will be determined according to state purchasing requirements.

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications)*:

Qualified Intellectual Disabilities Professional (QIDP) in accordance with 42 CFR 483.430a.

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3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Participants applying for 1915(i) state plan option services will be referred to the independent assessment provider (IAP) for initial eligibility determination.

The IAP will evaluate the participant using the Scales of Independent Behavior-Revised (SIB-R) and an Inventory of individual needs to determine if the participant meets the needs-based criteria. Reevaluations must be completed annually for current participants. The independent assessor must reassess the participant, or establish and document that the existing assessments reflect the participant's current needs.

4. ☒ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

- Require assistance due to substantial limitations in three or more of the following major life activities: self care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living or economic self sufficiency; and
- Reflect the need for a combination and sequence of special, interdisciplinary services due to a delay in developing age appropriate skills occurring before the age of 22.

5. ☒ **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits 1915(i) state plan option services to a group or subgroups of individuals:

Children, birth through age seventeen (17), who are determined to have a developmental disability in accordance with Sections 500 through 506 under IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits" and Section 66-402, Idaho Code.

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6. ☒ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
Require assistance due to substantial limitations in three or more of the following major life activities: self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self sufficiency; and Reflect the need for a combination and sequence of special, interdisciplinary services due to a delay in developing age appropriate skills occurring before the age of 22.	The participant requires nursing facility level of care when a child meets one (1) or more of the following criteria: **01. Supervision Required for Children.** Where the inherent complexity of a service prescribed by the physician is such that it can be safely and effectively performed only by, or under the supervision of a licensed nurse or licensed physical or occupational therapist. **02. Preventing Deterioration for Children.** Skilled care is needed to prevent, to the extent possible, deterioration of the child's condition or to sustain current capacities, regardless of the restoration potential of a child, even where full recovery or medical improvement is not possible. **03. Specific Needs for Children.** When the plan of care, risk factors, and aggregate of health care needs is such that the assessments, interventions, or	**01. Diagnosis.** Persons must be financially eligible for Medicaid; must have a primary diagnosis of being intellectually disabled or have a related condition defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition; and **02. Must Require Certain Level of Care.** Persons living in the community must require the level of care provided in an ICF/ID, including active treatment, and in the absence of available intensive alternative services in the community, would require institutionalization, other than services in an institution for mental disease, in the near future; and **03. Functional Limitations.** a. Persons Sixteen Years of Age or Older. Persons (sixteen (16) years of age or older) may qualify	The state uses criteria defined in 42 CFR 440.10 for inpatient hospital services.

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	supervision of the child necessitates the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and therapy notes. **04. Nursing Facility Level of Care for Children.** Using the above criteria, plus consideration of the developmental milestones based on the age of the child, the Department's will determine nursing facility level of care.	based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on a full scale functional assessment (Woodcock Johnson Scales of Independent Behavior, or SIB-R, or subsequent revisions) would qualify; or **b.** Persons Under Sixteen Years of Age. Persons (under sixteen (16) years of age) qualify if their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or **04. Maladaptive Behavior.** **a.** A Minus Twenty-Two (-22) or Below Score. Individuals may qualify for ICF/ID level of care based on maladaptive behavior. Persons will be eligible if their General Maladaptive Index on the Woodcock Johnson Scales of Independent Behavior (SIB-R) or subsequent revision is minus twenty-two (-22) or less; or **b.** Above a Minus Twenty-Two (-22) Score. Individuals who score above minus twenty-two (-22) may qualify for ICF/ID level of care if they engage in aggressive or self injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and the person requires active treatment	

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		to control or decrease the behavior; or 05. Combination Functional and Maladaptive Behaviors. Persons may qualify for ICF/ID level of care if they display a combination of criteria as described in Subsections 585.05 and 585.06 of these rules at a level that is significant and it can been determined they are in need of the level of services provided in an ICF/ID, including active treatment services. Significance would be defined as: (3-19-07) a. Persons Sixteen Years of Age or Older. For persons sixteen (16) years of age or older, an overall age equivalency up to eight and one-half (8 1/2) years is significant in the area of functionality when combined with a General Maladaptive Index on the Woodcock Johnson SIB-R up to minus seventeen (-17), minus twenty-two (-22) inclusive; or b. Persons Under Sixteen Years of Age. For persons under sixteen (16) years of age, an overall age equivalency up to fifty-three percent (53%) of their chronological age is considered significant when combined with a General Maladaptive Index on the Woodcock Johnson SIB-R between minus seventeen (-17), and minus twenty-one (-21) inclusive; or 06. Medical Condition. Individuals may meet ICF/ID level of care based	

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		on their medical condition if the medical condition significantly affects their functional level/capabilities and it can be determined that they are in need of the level of services provided in an ICF/ID, including active treatment services.	

(By checking the following boxes the State assures that):

7. [X] **Reevaluation Schedule.** Needs-based eligibility reevaluations are conducted at least every twelve months.

8. [X] **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. [X] **Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

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Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
   - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
   - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
   - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
   - An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
   - If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
   - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
2. ☒ Based on the independent assessment, the individualized plan of care:
   - Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
   - Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
   - Prevents the provision of unnecessary or inappropriate care;
   - Identifies the State plan HCBS that the individual is assessed to need;
   - Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
   - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
   - Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.
3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

At a minimum, the qualifications of the individuals conducting the independent assessment include:
1. Qualified Intellectual Disabilities Professional (QID) in accordance with 42 CFR 483.430 which includes:
   a. Having at least one (1) year experience working directly with persons with intellectual disabilities or other developmental disabilities or;
   b. Being licensed as a doctor of medicine or osteopathy, or as a nurse or;
   c. Having at least a bachelor's degree in one of the following professional categories: psychology, social work, occupational therapy, speech pathology, professional recreation, or other related human services professions.
2. Have training and experience in completing and interpreting assessments.

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4. **Responsibility for Plan of Care Development.** There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

The responsibility for service plan development and qualifications differ slightly based on the participant's selection of either traditional services or family-directed services.

Traditional Waiver Services:

The Department and its contractor(s) will be responsible for developing the plan of service in coordination with the participant and their family. Neither a provider of direct services to the participant nor the assessor may be chosen to develop the plan of service.

Case Management Qualifications:

Case Manager - Minimum of a Bachelor's Degree in a human services field from a nationally accredited university or college and have 24 months supervised experience working with children with disabilities, and pass a Department criminal history background check.

Clinical Case Management Supervisor - Minimum of a Master's Degree in a human services field from a nationally accredited university or college and have 12 months supervised experience working with children with disabilities, and pass a Department criminal history background check.

Family-Directed Waiver Services:

Under the family-directed model, a qualified parent is permitted to act as an unpaid support broker, or the family may choose to hire an approved support broker to purchase specific duties as needed.

The paid support broker may assist the family in developing and maintaining a support and spending plan. The plan must include the supports that the participant needs and wants, related risks identified with the participant's needs and preferences, and a comprehensive risk plan for each potential risk. This plan must be reviewed and prior authorized by the Department prior to implementation.

Specific qualifications are outlined in Idaho Administrative Code, IDAPA 16.03.13. It includes review of education, experience, successful completion of Support Broker training and ongoing education.

5. **Supporting the Participant in Plan of Care Development.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Participants who select State plan HCBS are given an orientation to developmental disability services by the IAP and their case manager. Participants and their parent/legal guardian may develop their own plan or use a case manager from the Department. If the participant and parent/legal guardian chooses to develop their own plan or use an unpaid natural support, the Department's case manager is available to assist in completing all required components. Family-centered planning must include at a minimum the participant (unless otherwise determined by the family-centered planning team), parent/legal guardian, and the case manager. With the parent/legal guardian's consent, the family-centered planning team may also include additional family members or individuals who are significant to the participant.

Participants and their parent/legal guardian who choose family-direction receive an orientation on family-direction and training from the Department. Families may select a qualified support broker to assist with writing the Support and Spending Plan, or they may choose to become a qualified support broker approved by the Department. As outlined in IDAPA 16.03.13, "Consumer-Directed Services," the participant and parent/legal guardian decides who will participate in the planning sessions in order to ensure the participant's choices are honored and promoted. The family may direct the family-centered planning meetings, or these meetings may be facilitated by a chosen support broker. In addition, the participant and parent/legal guardian selects a circle of support. Members of the circle of support commit to work within the group to help promote and improve the life of the participant in accordance with the participant's choices and preferences, and meet on a regular basis to assist the participant and parent/legal guardian to accomplish their expressed goals.

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6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

Once participants are determined eligible for services, they and their families are given an opportunity to participate in orientation training about developmental disability services in Idaho. During family orientation, participants and their families are provided with a list of all approved providers in the state of Idaho, which is organized by geographic area. This provider list includes the website link for the children's DD website at www.redesignforchildren.medicaid.idaho.gov so that participants and families have access to the most current providers in their area and across the state. Both the orientation and the provider list include a statement that the family may choose any willing and available provider in the state. Families are also informed of how to navigate the website to access the list of providers as well as how to access other helpful resources available to them.

Families are also provided with resources on interviewing potential providers and are encouraged to contact multiple providers to identify the provider that can best meet their needs. In addition, families are informed that who they select is their choice and they may change their choice of providers if they want. The case manager is utilized to assist families in selecting service providers at the family's request.

7. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

In both the traditional and family-directed options, the plan is developed by the participant and parent/legal guardian with their support team. The support team is typically comprised of the case manager or a support broker, the parent/legal guardian, at least one involved care giver and any friends, family or support staff that the family wants to invite. The number of people who can be involved is not limited. Besides the parent/legal guardian, the case manager is the only person who is required to be a member of the support team.

In the traditional model, the Department or its contractor develops the plan of service with the family. The contractor submits the plan of service to the Department for review and approval within 10 business days prior to the plan expiration date. Participants and their parents or legal guardians who choose to family-direct their services submit their Support and Spending Plan directly to the Department for review and authorization. The Department has ten (10) business days to review the plan. The participant and parent/legal guardian, and their circle of supports are in charge of how long the plan development process takes. The process may take from a few days to much longer, depending on the needs and wants of the participant, their family and the support team.

The IAP conducts and/or collects a variety of assessments and determines the participant's individual budget at the time of initial application and on an annual basis, for both the traditional and the family-directed option. The IAP conducts the following assessments at the time of the initial application for children's DD services:

- Scales of Independent Behavior – Revised (SIB-R) functional assessment.
- Medical, Social and Developmental Assessment Summary.

At the time of annual re-determination, the IAP conducts and/or reviews the following:

- The Medical, Social and Developmental Assessment Summary is reviewed and updated.
- The SIB-R results are reviewed and another assessment performed if there are significant changes in the participant's situation or the reassessment criteria are met.

The following assessments are gathered on an as-needed basis or may be used as historical information at the time of both initial and annual re-determinations:

- Psychological evaluations, including evaluations regarding cognitive abilities, mental health issues and issues related to traumatic brain injury.
- Neuropsychological evaluations.
- Physical, occupational and speech-language pathology evaluations.
- Developmental and specific skill assessments.

The results of a physical examination by the participant's primary care physician are provided to the case manager on an annual basis. Participants using traditional State plan HCBS, and their support team, must be assessed for health and safety issues. Participants using the family-directed option, and their support team, must complete safety plans related to any identified health and safety risks and submit them to the Department.

In the traditional option, the participant and parent/legal guardian's needs, goals, preferences and health status are summarized on the plan of service. This document is a result of the family-centered planning meeting listing a review of all assessed needs and participant and parent/legal guardian preferences. In addition, the case manager is responsible to collect data status reviews from all paid providers, synthesize all of the information and include it on the plan of service. The participant's parent/legal guardian sign the plan of service to indicate it is correct, complete, and represents the participant and parent/legal guardian's needs and wants.

Family-directed participant's needs, goals, preferences, health status, and safety risks are summarized on the Support and Spending Plan and in the Family Direction workbook. The circle of supports, using family-centered planning, develops these documents and submits them to the Department at the time of initial/annual plan review.

Participants and their parent/legal guardian, along with other members of the support team can receive information regarding State plan HCBS through several methods:

- The Department of Health and Welfare web site has a page specific for Children's DD Services that includes FAQ's, provider forms, rules, services, list of available providers, and other important resources. The website is found at www.redesignforchildren.medicaid.idaho.gov.

The Department of Health and Welfare's web site also has a page specific for family-directed services found at www.familydirected.dhw.idaho.gov.

- The IAP provides each new applicant with an informational packet which includes a listing of providers in the local area that provide developmental disabilities services for children, as well as a list of the services available under the children's DD program.

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- The case manager is charged with verbally explaining the various programs and options to the participant and parent/legal guardian during the family-centered planning process, under the traditional option.
- The support broker is charged with assisting the participant and parent/legal guardian to assess what services meet their needs, under the family-direction option.

Idaho requires that a family-centered planning process be utilized in plan development to ensure that participant goals, needs and preferences are reflected on the plan of service or on the Support and Spending Plan.

Case managers are trained in family-centered planning, and possess the education and experience needed to assist families in making decisions about their child's course of treatment and Medicaid services. The child's goals, needs, and resources are identified through a comprehensive review process that includes review of assessments and history of services, and family-centered planning.

Parents/legal guardians who choose to family-direct must attend training offered by the Department prior to submitting a Support and Spending Plan. Completion of this training is documented in the family-direction quality assurance database. The training covers participant and parent/legal guardian responsibilities in family-direction and the process of developing a Support and Spending Plan. The family-directed option utilizes a workbook and a support broker to ensure that the participant's individual goals, needs and preferences are thoroughly explored and prioritized during the plan development process.

Children's State plan HCBS participants typically receive a variety of services and other supports to address their needs and wants. The family-centered planning team works to ensure that the plan of service adequately reflects the necessary services. The plan of service is a single plan that includes the goals, objectives and assessment results from all of a child's services and supports in the child's system of care. The plan of service will demonstrate collaboration is taking place among providers and that objectives are directly related to the goals of the family.

Under the traditional option, the responsibility is placed on the case manager, IAP, and Department to complete the plan development process.

- The IAP is responsible to submit the assessment and individual budget to the Department.
- The Department assigns either a contracted case manager or Department staff to deliver case management and is responsible to:
  - Ensure that services are not duplicative, and are complementary and appropriate
  - Work with the members of the family-centered planning team and providers to ensure that the service needs of the participant are reflected on the plan of service
  - Act as the primary contact for the family and providers
  - Link the family to training and education to promote the family's ability to competently choose from existing benefits
  - Complete a comprehensive review of the child's needs, interests, and goals
  - Assist the family to allocate funding from their child's individual budget
  - Monitor the progress of the plan of service
  - Ensure that changes to the plan of service are completed when needed
  - Facilitate communication between the providers in a child's system of care

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Under the family-directed option, the responsibility is placed on the participant and parent/legal guardian to coordinate services with assistance from the Department and F/EA as required.

- The IAP is responsible to submit the assessment and individual budget to the Department.
- The family and a support broker use the Family-Direction Workbook and the family-centered planning process to identify the participant's needs and develop a Support and Spending Plan.
- The Department reviews the plan to ensure that all health and safety risks are covered.
- The Fiscal/Employer Agent (F/EA) ensures that duplication of payment does not occur.

Under the traditional model, the family-centered planning team must identify the frequency of monitoring but at a minimum it must occur at least annually. In addition, the plan must be monitored for continuing quality by the participant's case manager. Plan monitoring ensures that the plan of service continues to address the participant's goals, needs and preferences by requiring:

- Contact with the parent/legal guardian at least annually or as needed to identify the current status of the program and changes if needed. Changes may be made to the plan when a service is added or eliminated, when service objectives or goals are changed, when there is a change in provider, or when the child's level of needs change. The plan should be changed to ensure that the services continue to align with the child's individual budget and that the family is up to date on the services their child is receiving.
- Contact with service providers to identify barriers to service provision.
- Discussion about satisfaction regarding quality and quantity of services with the family.
- Review of provider status reports and complete a plan monitor summary after the six month review and for annual plan development.
- Reporting of any suspicion or allegation of abuse, neglect or exploitation to the appropriate authorities.

Participants and their parent/legal guardian who family-direct their services may choose to assume the responsibility of plan monitoring themselves, utilize members of the circle of supports, or require a support broker to perform these duties. This decision is made in the circle of supports during the family-centered planning process and is reflected in the Family-Direction workbook.

Each participant is required to complete a new plan of service annually. The IAP sends written notification 120 days prior to the expiration of the current plan. The notice requests that the family schedule a meeting with the IAP to begin the process of eligibility re-determination and annual budget determination. Families will work closely with the case manager and at any time can determine the need to add, decrease, or change services. Both plans and addendums will be reviewed by the Department.

Participants and their parent/legal guardian who are family-directing their services are required to complete a new Support and Spending Plan annually. Families can request changes be made to their Support and Spending plan at any time during the plan year by completing a plan change form and submitting to the Department for review.

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8. **Maintenance of Plan of Care Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

X	Medicaid agency	☐	Operating agency	X	Case manager
☐	Other (*specify*):				

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Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Respite
Service Definition (Scope):	
Respite provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver. Respite is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Respite may be provided in the participant's home, the private home of the respite provider, a developmental disabilities agency, or in community settings. Respite may only be offered to participants who have an unpaid primary caregiver living in the home who requires relief. Limitations: •Payment for respite services are not made for room and board. •Respite cannot be provided during the same time other Medicaid services are being provided to a participant. •Respite cannot be provided on a continuous, long-term basis where it is part of daily services that would enable an unpaid caregiver to work. • Respite cannot be provided as group- or center-based respite when delivered by an independent respite provider. •Respite services shall not duplicate other Medicaid reimbursed services.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
N/A	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
X	Categorically needy *(specify limits):*
	Subject to individual budget maximums.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed):*

Provider Type *(Specify):*	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Developmental Disabilities Agency		*Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative*	Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide respite in a DDA:

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		Code:	Providers must be at least 16 years of age when employed by a DDA; meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the participant and parent/legal guardian; have received care giving instructions in the needs of the participant who will be provided the service; demonstrate the ability to provide services according to a plan of service; and pass a criminal background check.
Respite Care Provider			Individuals must meet the following qualifications to provide respite: Providers must be at least eighteen (18) years of age and be a high school graduate, or have a GED; meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the participant and parent/legal guardian; have received care giving instructions in the needs of the participant who will be provided the service; demonstrate the ability to provide services according to a plan of service; pass a criminal background check; and must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter.
Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):			

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Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Developmental Disabilities Agencies	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns
Respite Care Provider	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover)*:

Service Title:	Habilitative Supports

Service Definition (Scope):

Habilitative Supports provides assistance to a participant with a disability by facilitating their independence and integration into the community. This service provides an opportunity for a participant to explore their interests, practice skills learned in other therapeutic environments, and learn through interactions in typical community activities.

Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization and relationship building, and participation in leisure and community activities.

This service is only provided in the participant's home or in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or therapy, nor are they intended to supplant the role of the primary caregiver.

The supports provider must maintain a log of the habilitative support services in the participant's record documenting the provision of activities outlined in the plan of service. Supports that take place in both the home and community must ensure the participant is actively participating in age appropriate activities and is engaging with typical peers according to the ability of the participant.

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Limitations:

Habilitative Supports cannot be provided during the same time other services are being provided to a participant.

Habilitative Supports shall not duplicate other Medicaid reimbursed services.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies)*:

☐ Categorically needy *(specify limits)*:

☒ Subject to individual budget maximums

☐ Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Developmental Disabilities Agency		Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.	Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide habilitative supports in a DDA: Must be at least 18 years of age; must be a high school graduate or have a GED; demonstrate the ability to provide services according to a plan of service; have received instructions in the needs of the participant who will be provided the service; pass a criminal background check; complete a competency course approved by the Department related to the support staff job requirements; and have six (6) months supervised experience working with children with developmental disabilities. Experience can be achieved in the following ways: I. Have previous work experience gained through paid employment, university practicum experience, or internship; or II. Have on-the-job supervised experience gained through employment at a DDA with increased supervision. In addition to the habilitative support qualifications, staff serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: - Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education, or closely-related coursework; or - Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist.

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Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Developmental Disabilities Agencies	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover)*:

Service Title: Family Education

Service Definition (Scope):

Family education is professional assistance to families to help them better meet the needs of the participant. It offers education to the parent/legal guardian that is specific to the individual needs of the family and child as identified on the plan of service. Family education is delivered to families to provide an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to their child's diagnoses. Family education may also provide assistance to the parent/legal guardian in educating other unpaid caregivers regarding the needs of the participant.

Family education providers must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. When family education is provided in a group setting, the group should consist of no more than five (5) participants- families.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies)*:

X	Categorically needy *(specify limits)*:
	Subject to individual budget maximums.
☐	Medically needy *(specify limits)*:

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Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Developmental Disabilities Agency		Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.	Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide family education in a DDA: Must hold at least a bachelor's degree in a health, human services, educational, behavioral science or counseling field from a nationally accredited university or college; must have one year experience providing care to children with developmental disabilities; must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide family education; and must complete a criminal history and background check.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Developmental Disabilities Agencies	Department of Health and Welfare	-At initial provider agreement approval or renewal -At least every three years, and as needed based on service monitoring concerns

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover)*:

Service Title:	Community Support Services
Service Definition (Scope):	

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Community Support Services provide goods and supports that are medically necessary and/or minimize the participant's need for institutionalization and address the participant's preferences for:

- Personal support to help the participant maintain health, safety, and basic quality of life.
- Relationship support to help the participant establish and maintain positive relationships with immediate family members, friends, or others in order to build a natural support network and community.
- Emotional support to help the participant learn and practice behaviors consistent with their goals and wishes while minimizing interfering behaviors.
- Adaptive support to help a child to learn new adaptive skills or expand their existing skills.
- Transportation support to help the participant accomplish their identified goals.
- Adaptive equipment identified in the participant's plan that meets a medical or accessibility need and promotes their increased independence.
- Skilled Nursing.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies)*:

- [X] Categorically needy *(specify limits)*:
  Subject to the individual budget amount.
- [ ] Medically needy *(specify limits)*:
  N/A

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Provider Qualifications *(For each type of provider. Copy rows as needed):*			
Provider Type *(Specify):*	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Community Support Agency	If required to identify goods or supports. For example, a Community Support providing speech-language pathology must have a current speech-language pathology licensure.	If required to identify goods or supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.
Community Support Provider	If required for identified goods or supports. For example, a Community Support providing speech-language pathology must have current speech-language pathology license.	If required for identified goods and supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.

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Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Community Support Agency	Participant and parent/legal guardian Paid Support Broker (if applicable) Department of Health and Welfare (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement
Community Support Provider	Participant and parent/legal guardian Paid Support Broker (if applicable) Department of Health and Welfare (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement

Service Delivery Method. (*Check each that applies*):	
X Participant-directed	☐ Provider managed

Service Specifications (*Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover*):

Service Title: Financial Management Services

Service Definition (Scope):

The Department will offer financial management services through any qualified fiscal employer agent (FEA) provider through a provider agreement.

FEA providers will complete financial consultation and services for a participant who has chosen to family-direct their services in order to assure that the financial information and budgeting information is accurate and available to them as is necessary in order for successful family direction to occur.

A. Payroll and Accounting. Providing payroll and accounting supports to participants that have chosen the family-directed community supports option;

B. Financial Reporting. Performing financial reporting for employees of each participant;

C. Financial Information Packet. Preparing and distributing a packet of information, including department approved forms for agreements, for the participant and family hiring their own staff;

D. Time Sheets and Invoices. Processing and paying timesheets for community support workers and support brokers, as authorized by the participant and parent/legal guardian according to the participant's Department authorized support and spending plan;

E. Taxes. Managing and processing payment of required state and federal employment taxes for the participant's community support worker and support broker;

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F. Payments for goods and services. Processing and paying invoices for goods and services, as authorized by the participant and parent/legal guardian according to the participant's support and spending plan;

G. Spending information. Providing each participant and parent/legal guardian with reporting information and data that will assist the participant and parent/legal guardian with managing the individual budget;

H. Quality assurance and improvement. Participation in department quality assurance activities.

FEA providers complete financial services and financial consultation for participants and their parent/legal guardian that is related to a family-directed participant's individual budget. The FEA assures that the financial data related to the participant's budget is accurate and available to them and their parent/legal guardian as necessary in order for successful family-direction to occur. FEA qualifications and requirements and responsibilities as well as allowable activities are described in Idaho Administrative Rules.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

N/A

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies)*:

☒ Categorically needy *(specify limits)*:

Only participants who select the family-directed option may access this service.

The FEA must not either provide any other direct services (including support brokerage) to the participant to ensure there is no conflict of interest; or employ the parent/legal guardian of the participant or have direct control over the participant's choice.

The FEA providers may only provide financial consultation, financial information and financial data to the participant and their parent/legal guardian, and may not provide counseling or information to the participant and parent/legal guardian about other goods and services.

☐ Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Fiscal Employer/Agent			Agencies that provide financial management services as a FEA must be qualified to provide such services as indicated in section 3504 of the Internal Revenue Code.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

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Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Fiscal Employer/Agent	Department of Health and Welfare	At the time of application, as indicated by a readiness review to be conducted by the Department for all FEA providers and thereafter at least every three years by Department review.
Fiscal Employer/Agent	Department of Health and Welfare	At the time of application, as indicated by a readiness review to be conducted by the Department for all FEA providers and thereafter at least every three years by Department review.

Service Delivery Method. *(Check each that applies)*:

X	Participant-directed	☐	Provider managed

Service Title: Support Broker

Service Definition (Scope):

Support brokers provide counseling and assistance for participants and their parent/legal guardian with arranging, directing, and managing services. They serve as the agent or representative of the participant to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. This includes providing participants and their parent/legal guardian with any assistance they need for gathering and reviewing their budget and financial data and reports prepared and issued to them by the FEA. Practical skills training is offered to enable families to remain independent. Examples of skills training include helping families understand the responsibilities involved with directing services, providing information on recruiting and hiring community support workers, managing workers and providing information on effective communication and problem-solving. The extent of support broker services furnished to the participant and parent/legal guardian must be specified on the support and spending plan.

Support broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant and parent/legal guardian's needs and preferences. At a minimum, the support broker must:

- Participate in the family-centered planning process.

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- Develop a written support and spending plan with the participant and family that includes the supports the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three backup plans should a support fall out. - Assist the participant and family to monitor and review their budget through data and financial information provided by the FEA. - Submit documentation regarding the participant and parent/legal guardian's satisfaction with identified supports as requested by the Department. - Participate with Department quality assurance measures, as requested. - Assist the participant and parent/legal guardian with scheduling required assessments to complete the Department's annual re-determination process as needed, including assisting the participant and parent/legal guardian to update the support and spending plan and submit it to the Department for authorization. In addition to the required minimum support broker duties, the support broker must be able to provide the following services when requested by the participant and parent/legal guardian: - Assist the participant and parent/legal guardian to develop and maintain a circle of support. - Help the participant and family learn and implement the skills needed to recruit, hire, and monitor community supports. - Assist the participant and parent/legal guardian to negotiate rates for paid Community Support Workers. - Maintain documentation of supports provided by each Community Support Worker and participant and parent/legal guardian's satisfaction with these supports. - Assist the participant and parent/legal guardian to monitor community supports. - Assist the participant and parent/legal to resolve employment-related problems. - Assist the participant and parent/legal to identify and develop community resources to meet specific needs. Support Brokers provide counseling and assistance for families by arranging, directing and managing services. This includes providing families with any assistance they need for gathering and reviewing their budget and financial data and reports prepared and issued to them by the FEA. Support Broker qualifications, requirements and responsibilities as well as allowable activities are described in Idaho Administrative Rules.
Additional needs-based criteria for receiving the service, if applicable *(specify):*
N/A
Specify limits (if any) on the amount, duration, or scope of this service for *(choose each that applies):*

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X	Categorically needy *(specify limits)*:
	Only participants who select the Family-Directed Option may access this service. Support brokers may not act as a fiscal employer agent, instead support brokers work together with the participant and parent/legal guardian to review participant financial information that is produced and maintained by the fiscal employer agent.
☐	Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Support Broker			Specific requirements outlined in Idaho Administrative Code - IDAPA 16.03.13 include review of education, experience, successful completion of Support Broker training and ongoing education. The parent/legal guardian can be an unpaid support broker for the participant and are subject to the same qualification requirements as paid support brokers.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Support Broker	Department of Health and Welfare	At the time of application, annual review of ongoing education requirement, and by participant and parent/legal guardian when entering into employment agreement.

Service Delivery Method, *(Check each that applies)*:

X	Participant-directed	☐	Provider managed

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2. Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians: There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Respite is the only State plan HCBS that may be provided by relatives of a participant. A parent/legal guardian cannot furnish State plan HCBS, but other relatives may be paid to provide respite services whenever the relative is qualified to provide respite as defined in this application. There are numerous safeguards in place to ensure that payments are only made for services rendered including oversight by provider agencies, family-centered planning teams, circles of supports, fiscal/employer agent, and by the Department through review and approval of plan of services and retrospective quality assurance reviews.

All providers are precluded from being in a position to both influence a participant and parent/legal guardian's decision making and benefit financially from those decisions. Payments for family-directed services rendered are made only after review and approval by the participant and parent/legal guardian and review by the Fiscal Employer Agent. Additionally, the participant's Support Broker and Circle of Supports are available to address any conflicts of interest.

Individual Budget Amount: There is a limit on the maximum dollar amount of HCBS State Plan services authorized for each specific participant.

(a) All HCBS services are included in the budget: Respite, habilitative supports, and family education. If the family chooses to family-direct their services, community support worker, paid support broker, and FEA services are included in the budget.

b) The state utilizes an individual budget model for children's developmental disabilities services that provides each child with an individual budget amount based on evidence-based research and level of care needs. The budget methodology includes a tiered approach using budget categories that range from addressing basic needs to intense early intervention needs.

The intent of the Children's Redesign Budget Methodology is to maximize budget distribution based upon the variable service needs of children with developmental disabilities. The budget methodology is based on a random sample analysis with a 95% confidence level. An 'Inventory of Individual Needs' assessment was completed on a random sample of eligible children with developmental disabilities to identify trends in the population that could be used for budget setting purposes. This methodology was determined to be the most effective way to manage budgets, whereas historical utilization was found to be unreliable and not a true reflection of appropriate utilization. The inappropriate utilization patterns were a result of a system driven by provider and family needs rather than the child's needs.

The sample findings were applied to the general Children's DD population, and the budgets were distributed based upon the service level needs of the participants and funds available. The children's budget methodology is driven by evidence-based research and is reflective of the children's continuum of services developed under the Redesign. The continuum of services creates a system based on needs – as children's needs become more involved they are able to access a wider array of services and the budget levels are increased accordingly.

The Department monitors the budgets on an ongoing basis to ensure that children's needs are accurately being reflected. The budget setting methodology will be evaluated on an annual basis using tracking reports established by the Department, and once sufficient data is collected on the population the findings may help the state identify improvements.

Initially, the state has identified that children who meet developmental disabilities criteria defined in IDAPA 16.03.10.501 qualify for a $4,900 budget for 1915i HCBS state plan services. Children who meet ICF/ID level of care will qualify for additional budget dollars when enrolled in a waiver program.

The IAP contractor makes the final determination of a child's eligibility, based upon the assessments administered by the

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IAP. The purpose of the eligibility assessment is to determine a child's eligibility for the DD program including if the child qualifies for ICF/ID level of care, and assigning a budget amount based on the funding level criteria.

Eligibility determination must be completed initially and on an annual basis for participants, and includes a functional assessment to reflect the child's current level of functioning. Once eligibility is completed, the IAP must provide the results of the determination to the family by sending a notice with appeal rights.

c) Ongoing monitoring of the budget model, complaints, appeals, and participant outcomes will be conducted by the Department to ensure that assigned budgets are sufficient to assure health and safety of participants in the community. When the Department determines that a change needs to be made to the budget methodology, participants will be sent notification of the change prior to implementation. The budget methodology is available on the children's redesign website for families and providers, and is included in administrative code. Changes to administrative code regarding the budget methodology will be subject to public feedback as part of the rulemaking process.

d) Families who believe that their child's assigned budget does not accurately reflect their needs may appeal the decision and request a fair hearing. Families may also submit an EPSDT request if they feel the amount of services are not sufficient to meet the medical needs of their child. Services under EPSDT are not subject to the child's budget.

e) A child's individual budgets will be re-evaluated at least annually. At the request of the family, the Department will also re-evaluate the set budget amount when there are documented changes that may support placement in a waiver or other program.

Families may request a re-evaluation at any point during the planning year by submitting the request to their case manager. The case manager will forward the request to the IAP, and a written notification will be sent to the family of the decision and the right to appeal.

f) Participants are notified of their eligibility for services and given an annual individual budget at the time of their initial determination or annual re-determination. Each participant receives written notification of the set budget amount. The notification includes how the participant may appeal the set budget amount decision. Individual budgets are re-evaluated annually by the IAP and written notifications of the set budget amount are sent annually.

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Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. **Election of Participant-Direction.** *(Select one):*

○	The State does not offer opportunity for participant-direction of State plan HCBS.
X	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. *(Specify criteria):*

2. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

Idaho's family-direction option provides a more flexible system, enabling participants and their parent/legal guardian to exercise more choice and control over the services they receive which helps them live more productive and participatory lives within their home communities. This option is provided within the existing system so that it is sustainable and reflects the value of this option for all participants and their parents/legal guardians who choose to direct their own services and supports. The process supports participant and parent/legal guardian preferences and honors their desire to family-direct their own services; how and when supports and services are provided; and who will assist them in developing and monitoring a realistic support and spending plan that accurately reflects their individual wants and needs.

Once participants are determined eligible for State plan HCBS, an individualized budget is developed for each participant. The budget model provides participants with an individual budget and a maximum level of funding that varies according to individual needs, and allows for spending flexibility within the set budgeted dollars. The support need is determined from an evaluation completed using a uniform assessment tool. Upon completion of the assessment, the individualized budget is reviewed with the participant and parent/legal guardian by the Department or its contractor.

Participants then have the option to choose Family-Directed Services (FDS). The FDS option allows eligible participants and their parent/legal guardian to choose the type and frequency of supports they want, to negotiate the rate of payment, and to hire the person or agency they prefer to provide those supports. Participants and the parent/legal guardian must use a support broker to assist them with the family-directed process. This can be accomplished in one of

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two ways. The family may choose to hire an approved support broker to perform specific duties as needed, or the parent/legal guardian may choose to act as an unpaid support broker with the ability to perform the full range of support broker duties. If a parent/legal guardian wishes to act as an unpaid support broker for the participant, they must complete the support broker training and be approved by the Department. Paid support broker services are included as part of the community support services that participants and their parent/legal guardian may purchase out of their allotted budget dollars.

Support broker duties include planning, accessing, negotiating, and monitoring the family's chosen services to their satisfaction. They can assist families to make informed choices, participate in a family-centered planning process, and become skilled at managing their own supports. The support broker possesses skills and knowledge that go beyond typical service coordination. The support broker assists participants and parents/legal guardians to convene a circle of supports team and engages in a family-centered planning process. The circle of supports team assists participants and parents/legal guardians in planning for and accessing needed services and supports based on their wants and needs within their established budget.

The FDS option gives participants and their parent/legal guardian the freedom to make choices and plan their own lives, authority to control the resources allocated to them to acquire needed supports, the opportunity to choose their own supports and the responsibility to make choices and take responsibility for those choices. Families and support brokers are responsible for the following:

- Accepting and honoring the guiding principles of family-direction to the best of their ability.
- Directing the family-centered planning process in order to identify and document support and service needs, wants, and preferences.
- Negotiating payment rates for all paid community supports they want to purchase.
- Developing and implementing employment/service agreements.

Families, with the help of their support broker, must develop a comprehensive support and spending plan based on the information gathered during the family-centered planning. The support and spending plan is reviewed and authorized by the Department and includes participant's preferences and interests by identifying all the supports and services, both paid and non-paid, and the participant's wants and needs to live successfully in their community.

Participants and their parent/legal guardian choose support services, categorized as "family-directed community supports," that will provide greater flexibility to meet the participant's needs in the following areas:

My Personal Needs - focuses on identifying supports and services needed to assure the person's health, safety, and basic quality of life.

My Relationship Needs – identifies strategies in assisting an individual to establish and maintain relationships with immediate family members, friends, spouse, or other persons and build their natural support network.

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My Emotional Needs – addresses strategies in assisting an individual to learn and increasingly practice behaviors consistent with the person's identified goals and wishes while minimizing interfering behaviors.
My Learning Needs - Identifies activities that support an individual in acquiring new skills or improving established skills that relate to a goal that the person has identified.

Participants and their parent/legal guardian choosing the Family-Directed Services option in Idaho are required to choose a qualified financial management services provider to provide Financial Management Services (FMS). The FMS provider is utilized to process and make payments to community support workers for the community support services contained in their support and spending plan. FMS providers have primary responsibility for monitoring the dollars spent in accordance with the itemized spending plan and for ensuring payment itemization and accuracy. Financial management service providers also manage payroll expenses including required tax withholding, unemployment/workers compensation insurance; ensuring completion of criminal history checks and providing monthly reports to the participant, parent/legal guardian and support broker if applicable. Financial Management service providers offer services on behalf of the participant in accordance with Section 3504 of the IRS code and the IRS Revenue Procedure 70-6, which outlines requirements of financial management service providers who are fiscal employer agents.

3. **Limited Implementation of Participant-Direction.** (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

X	Participant direction is available in all geographic areas in which State plan HCBS are available.
O	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the State affected by this option):*

4. **Participant-Directed Services.** *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
Community Support Services	X	X
Support Broker Services	X	X
Financial Management Services	X	X

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5. **Financial Management.** *(Select one):*

O	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
O	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.
X	Financial Services are furnished through a third party entity. *Specify whether governmental and/or private entities furnish these services.* ☐ Governmental entities X Private entities

6. X **Participant–Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

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6. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

The Department assists participants and the parent/legal guardian with this transition and assures that authorization for services under family-direction do not expire until new services are in place. The Department provides technical assistance and guidance as requested by participants and their parent/legal guardian, support brokers, and circles of support. Transition from family-direction to traditional services will not take more than 120 days and in most cases will be accomplished in 60 to 90 days. This transition time is spent re-determining the LOC needs, development of a new plan, and review and authorization of the new plan. The participant remains in family-direction until this process is completed so that there is no interruption in services. If at any time there are health and safety issues, the Department works closely with the participant and parent/legal guardian to ensure that the participant's health and safety is protected. This may include utilizing the Crisis Network Team to address any immediate crises and/or authorizing an emergency 120-day transition plan to assure a smooth transition from family-directed services to traditional services.

Only demonstrated danger to the participant's health and safety would result in the involuntary termination of the participant's use of family-direction. In these cases, the Department will work closely with the parent/legal guardian and support broker to identify necessary changes to the plan of service, authorize emergency services if necessary, and facilitate any other activities necessary to assure continuity of services during this transition.

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(Select one):*

○	The State does not offer opportunity for participant-employer authority.	
X	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide State plan HCBS. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	X	**Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide State plan HCBS. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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b. Participant–Budget Authority (individual directs a budget). *(Select one):*

O	The State does not offer opportunity for participants to direct a budget.
X	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	The same budget methodology used for the traditional option is applied for the family-directed services option. See page 33 of this Supplement 1 to Attachment 3.1-A for the complete description.
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):*

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	The participant and parent/legal guardian's selected Fiscal Employer Agent will have the individual budget and the approved supports and services from the support and spending plan. They will send monthly statements to participants and their parent/legal guardian on a monthly basis to inform them on the status of expenditures. The support broker will assist the family to review these statements to assure spending is on track. Employment agreements are developed for each community support worker that are descriptive to what is expected and how they will be paid. As part of the QA process, Medicaid staff monitors to assure that processes are in place to monitor these expenditures. Each fiscal agent is required to: 1) Have a system in place to perform a quarterly quality management (QM) analysis activity on a statistically significant sample of overall participant records; 2) Have documented, approved policies and procedures with stated timeframes for performing a quarterly quality management analysis activity on a statistically significant sample of overall participant records; 3) Have internal controls documented and in place for performing a quarterly QM analysis activity on a statistically significant sample of overall participant records; 4) Forward QM reports to the Department within thirty (30) working days from the end of each quarter. In addition to reviewing these quarterly reports, the Department also conducts a full service performance check on each fiscal agent provider at least every 3 years (all policies and procedures, and all the task and services as agreed upon in the provider agreement).

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Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes,and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	1. Participants report satisfaction with their participation in activities within their communities.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	2. Service plans are reviewed and approved prior to the expiration of the participant's current plan of service.	100% of individual service plans (ISP) will be reviewed by the Department for prior authorization.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	3. Participants report their comments, questions and ideas were solicited and encouraged during the person-centered planning meeting.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	4. Participants report they make choices about their everyday life.	Compliance is based on weighted measure of series of PES questions. Annual PES will be completed for a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually

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	5. Participants report they received support to learn something new in the past year.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	6. Participants report they know their plan developer/ monitor.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	7. Participants report their plan developer / monitor helps them get what they need.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	8. Requests to modify plans of service are reviewed and approved or denied within fifteen (15) days of their receipt.	Plan Authorization complete using representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	9. Claims indicate utilization consistent with the service type, scope, amount, duration and frequency approved on the participant's service plan.	System Data is reviewed for a representative sample with +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	10. Number and percent of service plans reviewed that addressed participant's functional needs as identified by the assessment.	100% of Service Plans are reviewed yearly by the Department and its contractor, and Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually

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	11. Number and percent of participants report they were given a choice when selecting service provider(s).	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	12. Number and percent of participants reviewed who reported they have access to the services and supports they need.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	13. Number and percent of participants reviewed whose plan goal was achieved or modified in the past year.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
Providers meet required qualifications.	1. Number and percent of direct care staff meets state requirements for training.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	2. Number and percent of service providers, by provider type, who require licensure or certification have a current license or certificate at the time they provide Medicaid services to DD participants.	System Data will be used to verify that 100% of service providers have current certification or licensure as required.	Department of Health and Welfare	Every 3 years	Department of Health and Welfare	Every 3 years
	3. Number and percent of non-licensed, non-certified service providers, by provider type, who demonstrate compliance with minimum provider requirements.	System Data will be used to verify that 100% of service providers serving a representative sample of participants demonstrate compliance with minimum provider requirements.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually

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The SMA retains authority and responsibility for program operations and oversight.	1. Number and percent of deficiencies corrected by the contractor as identified by the Department contract monitor	System Data is used to verify that 100% of all contractual obligations are addressed.	IAP Contractor	Ongoing and Quarterly	Department of Health and Welfare	Quarterly
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	1. Number and percent of demonstrated 1915(i) service providers fraudulent billing patterns investigated by DHW and action taken.	System Data is used to verify that 100% of the time appropriate investigation and follow up occurs when fraudulent billing is identified.	Department of Health and Welfare	Ongoing	Department of Health and Welfare	Ongoing and Annually
	2. Number and percent of invoices paid by Fiscal/Employer Agent in excess of the amount approved for identified support categories on each participants support and spending plan.	System Data will be used to demonstrate that 100% of the time appropriate Department investigation and follow up occurs when fraudulent billing is identified.	Department of Health and Welfare	Provider performance monitoring - Ongoing Financial Audits - Quarterly	Department of Health and Welfare	Ongoing, Quarterly and Annually
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1. Number and percent of direct service providers who have signed a self declaration form and have not disclosed any designated crimes prior to working with participants.	System Data will demonstrate that 100% of service providers providing direct services to participants in the representative sample have signed declaration forms.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	2. Number and percent of participants who reported that their service providers were reliable.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually

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	3. Number and percent of participants who reported that they are free from abuse, neglect and exploitation.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	4. Number of participants reviewed that reported they know the person/place to go to in order to report abuse.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	5. Number and percent of critical incidents that are investigated consistently with priority guidelines.	System data is used to verify the 100% of the time incidents are investigated consistently with guidelines.	Department of Health and Welfare	Ongoing	Department of Health and Welfare	Quarterly and Annually
	6. Number and percent of participants who reported support staff treated them with respect.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	7. Number and percent of participants who have had an annual medical evaluation.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	8. Number and percent of participants reviewed who have had a dental exam once every 6 months.	Participant Experience Survey (PES) will be completed annually on a representative sample with a +/- 5% confidence interval.	Department of Health and Welfare	Annually	Department of Health and Welfare	Annually
	9. Number and percent of critical incidents substantiated by type.	System data is used to verify the 100% of the time critical incidents are substantiated by type of incident.	Department of Health and Welfare	Ongoing	Department of Health and Welfare	Quarterly and Annually
	10. Number of substantiated complaints, by type.	System data is used to verify the 100% of the time complaints are substantiated by type of complaint.				

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System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*				
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles	Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
☐ PBS results are gathered. ☐ Regional complaints and incident reports are investigated. ☐ Individual plans of service are reviewed by the Department.	Quality Management Staff.	This is a group of staff across seven regions of Idaho, with knowledge of quality improvement interventions, and who are responsible for collecting and reporting data to the Department.	Ongoing.	Data is gathered and submitted to the Department's analyst.
☐ Results of PBS are reviewed and analyzed, and tabulated. ☐ Complaints and Critical Incidents are reviewed, analyzed, and tabulated. ☐ Plan of service information is analyzed.	Department Analyst.	This is department staff identified that lead statewide data collection activities, analysis, and reporting activities related to quality management. This staff is responsible for creating and implementing data collection tools.	Ongoing.	The analyzed data is presented to the QA team for review and prioritization.
☐ Quarterly meetings: Quarterly the committee reviews analyzed data to develop recommendations for program improvements, and reviews actions taken and progress made toward implementing previous approved system improvements. ☐ Annual meeting: Meets annually to prioritize findings and develop recommendations for specific system improvements for the coming year. This recommendation will be submitted to administration for approval and assignment.	Quality Management Team.	The QM team is responsible for steering the quality assessment and improvement process, and issues related to parallel data collection. It is responsible for formally recommending specific program improvements to Department administration.	Quarterly.	Annual QM report is submitted to administration.
☐ Quarterly QM Report. ☐ Annual QM Report.	Quality Management Manager.	The QM manager takes overall responsibility for leading team members, finalizing quarterly and yearly QM reports, leading the process of prioritizing needs for system improvements, and implementing approved system improvements.	Quarterly and Yearly Report.	Overall data findings and recommendations are submitted to the QM Team for review prior to finalization.

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Methods and Standards for Establishing Payment Rates

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

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
X	HCBS Habilitation Refer to attachment 4-19-B
X	HCBS Respite Care Refer to attachment 4-19-B
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
Other Services:	
X	Family Education Refer to attachment 4-19-B
Supports for Participant Direction:	
X	Community Support Services Refer to attachment 4-19-B
X	Support Broker Refer to attachment 4-19-B
X	Financial Management Services Refer to attachment 4-19-B

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

FEB 20 2014

Justin M. Senior
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Dear Mr. Senior:

This letter provides notice that the Centers for Medicare & Medicaid Services (CMS) has found that Florida is not providing all Medicaid beneficiaries with outpatient hospital benefits required under title XIX of the Social Security Act (the Act) and that until this deficiency is corrected (by making outpatient hospital services available to all beneficiaries entitled to such services), a portion of the Federal funding of the administrative costs associated with the operation of the Florida Medicaid program will be withheld, subject to the opportunity for Florida to request a hearing on this finding. The details of the finding, proposed withholding, opportunity for a hearing, and possibility of postponing and ultimately avoiding withholding by coming into compliance, are described in detail below.

Specifically, CMS has found that Florida is not providing beneficiaries with medical assistance for outpatient hospital services in accordance with the approved Florida State Plan, specifically by imposing numeric limits (six visits annually) on coverage of outpatient hospital visits furnished in hospital emergency departments. The approved state plan does not contain any numeric limitation on coverage of outpatient hospital services or services of a hospital emergency department. It is our understanding that Florida is nevertheless imposing a numeric limitation on such coverage.

This issue is related to the disapproval of a proposed state plan amendment that would have placed numeric limitations on outpatient hospital visits furnished in a hospital emergency department. Florida submitted the proposed amendment to the coverage provisions of the Medicaid state plan on September 14, 2012, to impose a limit of 6 visits per year to emergency departments. The proposed state plan amendment would have been effective on August 1, 2012. CMS disapproved the amendment on December 13, 2012, indicating that the limitation on outpatient services was not consistent with the requirements of section 1902 of the Social Security Act and implementing regulations because the limitation: 1) would not be consistent with the mandatory nature of the outpatient hospital services benefit under section 1902(a)(10)(A); 2) would not be a reasonable standard consistent with section 1902(a)(17) of the Act because it would arbitrarily deny coverage of outpatient hospital services, a mandatory benefit, based on the (emergency) condition of the patient; and 3) would not be consistent with the best interests of beneficiaries as required by section 1902(a)(19).

EXHIBIT D

In disapproving the amendment, CMS suggested to the state some alternate methods to address inappropriate utilization of hospital emergency rooms, including the development of payment rates for hospital emergency rooms that are lower if the individual does not require care for an acute and immediate condition, or the use of the alternative cost sharing authority available to states under section 1916(d) of the Act, permitting higher beneficiary cost sharing for elective non-emergency use of the emergency room. CMS offered to work with the state on these options and technical assistance.

Florida requested reconsideration of the CMS disapproval of the amendment in February 2013. In the CMS response, CMS noted that the disapproval was also supported because the proposed coverage limitations has an exception to the limitation on emergency room visits for "aliens" that would violate the "comparability" requirements of section 1902(a)(10)(B) of the Act because it would provide that aliens would receive a greater amount, duration, and scope of emergency outpatient hospital benefits than other individuals described in section 1902(a)(10)(A) of the Act.

During the course of the reconsideration process, CMS learned that Florida had implemented the six visit limit on hospital emergency department visits and was still applying the limit after the proposed amendment was disapproved. This means that Florida is not operating its program in accordance with the approved state plan. It should also be mentioned that Florida's submission of its quarterly expenditure reports through the CMS-64, includes a certification that the state is operating under the authority of its approved Medicaid state plan.

In light of our obligation to ensure that beneficiaries receive services to which they are entitled under the approved state plan, I am taking this compliance action to withhold a portion of the Federal Financial Participation in state expenditures for administrative costs necessary to administer the Florida Medicaid program, subject to the opportunity for a hearing described below, until such time as I am satisfied that the state is complying with the Federal requirements described above. The withholding will initially be 10 percent of the Federal share of the state's quarterly claim for administrative expenditures allocable to outpatient hospital services, using an allocation method based on the proportion of total state Medicaid expenditures that were for outpatient hospital expenditures, as reported on Form CMS-64. The withholding percentage will increase by 5 percentage points (i.e. 15 percent, 20 percent, etc.) for every quarter in which the state remains out of compliance, up to a maximum withholding percentage of 100 percent (of administrative expenditures allocable to outpatient hospital services). The withholding will end when Florida implements a corrective action plan to bring its Medicaid program into compliance with Federal requirements.

The state has 30 days from the date of this letter to request a hearing. As specified in the accompanying Federal Register notice, we are providing an opportunity for an administrative hearing to ensure that you have an opportunity for a hearing prior to this determination becoming final. However, it is up to the state whether to go forward with this hearing. If a request for a hearing is timely submitted, the hearing will be convened by the Hearing Officer designated below no later than 60 days after the date of the Federal Register notice, or a later date by agreement of the parties and the Hearing Officer, at the CMS Regional Office in Atlanta, Georgia, in accordance with the procedures set forth in Federal regulations at 42 CFR Part 430, Subpart D. The overall issue in any such appeal will be whether the Florida outpatient hospital

benefit is consistent with Federal requirements. Any request for such a hearing should sent to the designated Hearing Officer. The Hearing Officer also should be notified if you request a hearing but cannot meet the timeframe expressed in this notice. Your Hearing Officer is:

Benjamin R. Cohen, Hearing Officer
Centers for Medicare & Medicaid Services
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244

If the state requests a hearing but nevertheless plans to come into compliance with the approved state plan, please submit within 30 days of the date of this letter an explanation of how the state plans to come into compliance with Federal requirements and the timeframe for doing so. If that explanation is satisfactory, we may consider postponing the timing of the scheduled hearing (which would also delay the imposition of the withholding of funds). Our goal is to ensure compliance. We are available to provide further information or assistance on the steps necessary to bring the state into compliance with its approved state plan.

Should you not request a hearing within 30 days, a notice of withholding will be sent to you and the withholding of Federal funds will begin as described above.

If you have any questions or wish to discuss this determination further, please contact:

Jackie Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
CMS Atlanta Regional Office
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

Sincerely,

Marilyn Tavenner