DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **13-007**

2. STATE: **IDAHO**

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

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

4. PROPOSED EFFECTIVE DATE
~~January 1, 2013~~ April 6, 2013 (P&I)

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
1905(a)(6), 1905(a)(12) and 2110(a)(24) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
Total ($) Federal Funds
FFY 2013 ($0)
FFY 2014 ($0)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, pages 19a (new page)
Attachment 3.1-C (P&I)
BBBP page 26
EBBP pages 29 and 51

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1-C (P&I)
BBBP page 26
EBBP pages 29 and 51

10. SUBJECT OF AMENDMENT:
The proposed change will create a payment method for an out-of-state placement in a Psychiatric Residential Treatment Facilities (PRTF) which will satisfy a paticipant's EPSDT need for PRTF services that are not a covered Medicaid benefit in Idaho.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Paul J. Leary

14. TITLE:
Administrator

15. DATE SUBMITTED: 3/29/13

16. RETURN TO:
Paul J. Leary, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0036

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 03/29/2013

18. DATE APPROVED: June 13, 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 6, 2013

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Carol J.C. Peverly

22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health

23. REMARKS:

5.9.13 The State authorize a P&I change to the original HCFA 179, boxes 8 and 9.
5.30.13 The State authorize a P&I change to the original HCFA 179 box 4.