IDAHO DEPARTMENT OF
HEALTH & WELFARE

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December 20, 2024

Alex Desatoff
Demonstration Project Officer
Center for Medicaid and CHIP Services (CMCS)

Dear Alex Desatoff:

The Idaho State Medicaid Agency is requesting an amendment to the 11-W-00339/10: 1115 IMD Behavioral Health Transformation Demonstration to remove an approved expenditure authority.

The State Medicaid Agency requests that the language below be removed from Idaho's 1115 demonstration waiver authority.

> *2. **Use of Legally Responsible Individuals (LRI) to Render Personal Care Services (PCS).** The state will provide payment for PCS rendered by an LRI, which could be inclusive of legally responsible family caregivers, for beneficiaries eligible to receive 1905(a) personal care services through the Idaho Medicaid state plan providing that the state meets all existing requirements as described under the Medicaid state plan, including Electronic Visit Verification requirements. The requested LRI must meet all qualifications to become a direct care worker to provide PCS as authorized in the Medicaid state plan, including abiding by all oversight requirements from the hiring agency and the Idaho Department of Health and Welfare. A beneficiary can receive PCS from a non-LRI beyond the hours provided by an LRI in accordance with a beneficiary's assessed need and the plan of care. The state shall implement a phased-in approach, which will be detailed in the monitoring reports and must be submitted to CMS at least sixty (60) days in advance of implementation, for the following conditions that must be met for a beneficiary to receive PCS from an LRI:*
> *a. **Extraordinary Circumstance.** A beneficiary must demonstrate their care needs meet an extraordinary circumstance to allow for an LRI to provide PCS. An extraordinary circumstance is defined as no other caregiver being available to meet all of the beneficiary's allocated hours.*
> *b. **Application Requirement.** The beneficiary must have attempted to arrange for a non-LRI direct care worker to provide needed PCS. The beneficiary must demonstrate a minimum of two unsuccessful attempts to obtain PCS from providers that are not an LRI.*

The current structure of this expenditure authority has led to unanticipated and unsustainable growth in the program that cannot be appropriately managed and overseen within the State Medicaid Agency's current resources. Further, the State Medicaid Agency has identified a concerning volume of incidents of suspected and confirmed fraud and abuse and healthy and safety concerns that the State Medicaid Agency cannot resolve within the program's current parameters and staff capacity.

This amendment request aligns with 42 C.F.R. Part 431 Subpart G - Section 1115 Demonstrations, as further defined in the CMS approved Standard Terms and Conditions of the state's approved 1115 demonstration.

The State Medicaid Agency requests an effective date of January 31, 2025.

Idaho appreciates your review of this amendment request and anticipates CMS approval. Please direct any questions to Charles Beal, Medicaid Policy Director, at charles.beal@dhw.idaho.gov.

Sincerely,

[redacted]

JULIET CHARRON
Deputy Director

JC/ah

cc: Courtenay Savage, Julie Sharp

Idaho Department of Health and Welfare

Section 1115 Medicaid Demonstration Amendment Request:

Removal of Expenditure Authority For
Use of Legally Responsible Individuals
to Render Personal Care Services (PCS)

December 20, 2024

Table of Contents

Section I. Background and Overview

A. Background

During the COVID-19 public health emergency, the federal Centers for Medicare and Medicaid Services (CMS) allowed a temporary flexibility to decrease the need for direct care workers in people's homes to prevent the spread of COVID-19.

Specifically, CMS allowed Family Personal Care Services (FPCS), the paid employment of legally responsible parents and spouses by direct care staffing agencies while providing care in their own homes for their loved ones who are Medicaid participants with disabilities. Prior to this temporary change, legally responsible individuals were expressly prohibited by both federal and state regulation from being paid personal care aides.

With the end of the federally declared public health emergency in 2023, the State Medicaid Agency faced the decision whether to terminate or continue this policy flexibility. The continuing direct care workforce shortage and concern expressed by stakeholders led the State Medicaid Agency to request and secure CMS approval to extend this flexibility through March 21, 2025, with limited safeguards given current staff capacity to oversee the program. The State Medicaid Agency had extensive technical assistance with CMS during this time. In early 2024 the Department started a stakeholder workgroup to discuss future changes to the benefit with the intent to possibly amend requirements with the March 2025 renewal.

Stakeholders are aware that the current authority supporting FPCS will end in March 2025, unless the State Medicaid Agency is authorized and funded to continue it in some form. To date, the stakeholder group has asked the State Medicaid Agency to further loosen the program's few restrictions.

Stakeholders requested less frequent in-home health and safety visits and an expanded scope of responsibilities for parents to take on and be paid for beyond what is currently authorized. To date, the State Medicaid Agency has responded that the program is under review and those recommendations will be taken into consideration.

The State Medicaid Agency is not currently resourced to continue to support this program and ensure health and safety as well as operational integrity, given its exponential growth and number of concerning trends identified of fraud, waste, and abuse.

B. Overview

The current structure of this expenditure authority has led to unanticipated and unsustainable growth in the program that cannot be appropriately managed and overseen within the State Medicaid Agency's current resources. Further, the State Medicaid Agency has identified a concerning volume of incidents of suspected and

confirmed fraud and abuse and healthy and safety concerns that the State Medicaid Agency cannot resolve within the program's current parameters and staff capacity.

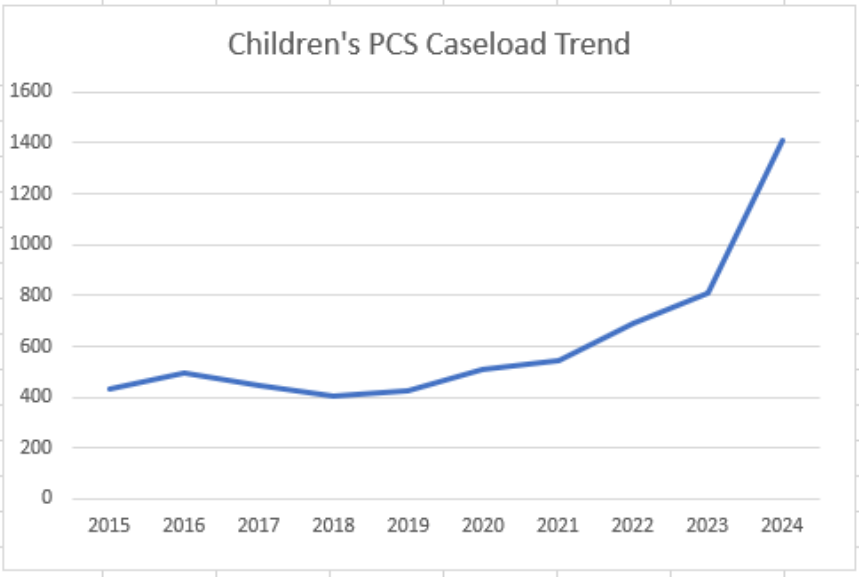
In the role as stewards of taxpayer dollars and oversight of this program serving vulnerable children and adults, the State Medicaid Agency has determined the most appropriate action is to move to terminate this expenditure authority allowing Legally Responsible Individuals to be reimbursed as PCS providers effective January 31, 2024.

This action will not remove Personal Care Services (PCS) as a State Plan Benefit, which will remain available as it has prior to COVID-19 and staffed by direct care professionals through provider agencies.

Historically across successive fiscal years dating as far back as 2015, there were roughly five hundred (500) participants in children's personal care and private duty nursing services. Enrollment jumped to five hundred forty-six (546) in 2021, and significantly increased in each subsequent year. In October 2024, the State Medicaid Agency had one thousand one hundred seventy-eight (1,178) participants in the program, and projected enrollment at one thousand four hundred thirteen (1,413) by the end of calendar year 2024.

This represents a seventy-five percent (75%) increase in enrollment since 2023 when the public health emergency ended. The growth in enrollment at this rate was not projected and is not sustainable within the State Medicaid Agency's budget if this continues. While expenditures are based on authorized hours of services that are approved by clinical staff, the State Medicaid Agency is aware of many inappropriate attempts to increase the number of authorized hours by families which are further described below.

Year	Children's PCS Caseload Trend
2015	434
2016	493
2017	446
2018	402
2019	426
2020	507
2021	546
2022	688
2023	809
2024	1413
	*1,178 as of 10/29/24



This ongoing enrollment surge is due in part to suspected program abuse. The State Medicaid Agency has observed that some parents, spouses, and provider agencies are trading tips on how to seemingly exploit this program. This includes:

- Sharing information on how to manipulate and respond to the medical assessment to maximize authorized hours of service.
- Photocopying and sharing eligibility paperwork rather than obtaining independent confirmation from two (2) direct care staffing agencies that they have insufficient staff to serve the child/spouse (as required by the program).
- Recruiting families outside Idaho to move to Idaho to be paid for these services.
- Advertising to employ parents to care for their child(ren) with special needs, saying there is, "No need to work away from home." This incentivizes parents who never previously had a need or interest in these services to apply.
- Communicating the starting pay rates for area provider agencies, resulting in participants switching agencies *not* due to a quality-of-care concern, but exclusively to maximize the household's income.

Other suspected fraudulent and concerning activities include:

- Claiming to care for children but performing other activities at the same time (i.e., driving for a ride share company).
- Inappropriately double- and triple-billing by caring and billing for multiple children simultaneously (the program only allows a provider to care for one (1) individual at a time). This also presents serious questions of quality and adequacy of care when the child has been identified to need a specific number of hours of care, but it is physically impossible for the parent to serve multiple children for those hours. This includes parents logging more than twenty-four (24) hours in a day as confirmed by electronic visit verification (EVV).
- Using Medicaid as supplemental household income by determining the needs of the child(ren) on the income received. To quote one parent, "I want PCS for four of my kids. When I find out what my income will be, I might get PCS for [the others]."
- Repeatedly calling State Medicaid Agency staff to inquire about the status of assessments and actively encouraging others to do the same, taking time away from employees completing those assessments and work for the other Medicaid participants.
- Households that have had continuous Medicaid coverage in the past, but never requested or identified a need for a child (or children) in the household to receive PCS until this flexibility was implemented, with no discernible change in the child's condition that would warrant said request.

- Instances in which one individual is clocking in and out of services for multiple participants in multiple households that appear to be efforts to avoid detection by quality assurance monitoring of EVV data. In the last calendar quarter, one individual clocked in and out with overlapping visit segments (which is prohibited) for twenty-one (21) FPCS participants.
- Households selectively providing service hours to attempt to control income that would affect eligibility for other public benefits, which suggests that the child did not medically require the total number of hours authorized.

The State Medicaid Agency can supply copies of evidence and support of all of these instances and others upon request.

Not only has enrollment increased, but costs have also nearly quadrupled since 2022 and are not sustainable within the current appropriation if this growth trend continues.

As stewards of public funds and in the role of oversight of this entitlement program serving vulnerable children and adults, the State Medicaid Agency cannot continue to operate a program with such high rates of suspected and known fraud and abuse and potential health and safety issues for participants.

Many of these cases have come to the State Medicaid Agency's attention through complaints or observed and experienced interactions with families, content posted on social media, referrals from other state agencies that serve the same population, and referrals by word of mouth from community partners and individuals. While several of these cases have been referred to the Medicaid Program Integrity Unit, the State Medicaid Agency does not have the infrastructure to administratively identify all cases needing additional inquiry and pursuing recovery. Moreover, if a household / family is perpetrating fraud, any recovery of funds would be from the agency that technically employs the parent / spouse, thereby weakening Idaho's already tenuous network of direct care agencies.

The State Medicaid Agency recognizes that there are still many families who use this benefit and program appropriately, legitimately need support, and cannot find direct care workers to provide services to their children. The State Medicaid Agency has actively engaged in marketing and outreach activities to bolster the direct care workforce in Idaho over the last two (2) years and has observed an approximately ten percent (10%) growth in the number of unduplicated direct care workers, not including parents and spouses, as identified in the State Medicaid Agency's Electronic Visit Verification data. The State Medicaid Agency will share options through external communications to agencies and families during this transition. State Medicaid Agency staff are always available to families and provider agencies to discuss options.

At the same time, it is evident over the last year alone of operationalizing this flexibility that the State Medicaid Agency does not currently have the resources to

build an infrastructure to determine what is acceptable and then meaningfully monitor and enforce those standards to promote healthy and safety and appropriate use of public funds.

The State Medicaid Agency team responsible for administration and oversight of the FPCS program will be implementing additional safeguards and operational processes to provide as much oversight as possible during the remaining months of the FPCS flexibility. These activities will include:

- Processing timeframes for new requests will be moved to thirty (30) days. The current timeframe is fourteen (14) days. The team is unable to maintain fourteen (14) days without detrimental impact to other programs and services administered by these staff.
- Quarterly supervisory oversight forms submitted by provider agencies will require a narrative to validate that each visit did, in fact, occur and is reflective of adequate clinical oversight.
- Functional assessments for whom the primary respondent is also the direct care worker (including parents and spouses) will be subject to post-processing internal review by the Medical Director to validate that PCS are medically necessary. Additional medical documentation to substantiate the participant's ongoing need for services may be requested.

In addition, the Medicaid Program Integrity Unit is actively pursuing recoupments and assessing penalties as appropriate and will refer all credible allegations of fraud to the Medicaid Fraud and Control Unit.

Section II: Description of the Amendment

Effective January 31, 2025, the State Medicaid Agency is requesting an amendment to the 1115 Research and Demonstration Waiver, Project Number 11-W-00339/10, to remove an approved expenditure authority.

This requested amendment does not remove Personal Care Services as an available benefit for those served by Idaho Medicaid, which will continue to be available as a State Plan benefit.

Rather, the State Medicaid Agency seeks to amend who can qualify as a provider and can render the service for Medicaid reimbursement. The State Medicaid Agency will revert back to the same criteria and qualifying providers as existed pre-COVID-19. With concerted efforts and rate increases to bolster the direct care workforce, PCS provider agencies have reported a ten percent (10%) increase in the number of staff hired and who will be available to serve participants receiving PCS services. Please note, the State Medicaid Agency continues to work on several concerted efforts to support the direct care workforce beyond what has been done to date.

The State Medicaid Agency requests that the language below be removed from Idaho's 1115 demonstration waiver authority.

> ***2. Use of Legally Responsible Individuals (LRI) to Render Personal Care Services (PCS).*** *The state will provide payment for PCS rendered by an LRI, which could be inclusive of legally responsible family caregivers, for beneficiaries eligible to receive 1905(a) personal care services through the Idaho Medicaid state plan providing that the state meets all existing requirements as described under the Medicaid state plan, including Electronic Visit Verification requirements. The requested LRI must meet all qualifications to become a direct care worker to provide PCS as authorized in the Medicaid state plan, including abiding by all oversight requirements from the hiring agency and the Idaho Department of Health and Welfare. A beneficiary can receive PCS from a non-LRI beyond the hours provided by an LRI in accordance with a beneficiary's assessed need and the plan of care. The state shall implement a phased-in approach, which will be detailed in the monitoring reports and must be submitted to CMS at least sixty (60) days in advance of implementation, for the following conditions that must be met for a beneficiary to receive PCS from an LRI:*
> *a.* ***Extraordinary Circumstance.*** *A beneficiary must demonstrate their care needs meet an extraordinary circumstance to allow for an LRI to provide PCS. An extraordinary circumstance is defined as no other caregiver being available to meet all of the beneficiary's allocated hours.*
> *b.* ***Application Requirement.*** *The beneficiary must have attempted to arrange for a non-LRI direct care worker to provide needed PCS. The beneficiary must demonstrate a minimum of two unsuccessful attempts to obtain PCS from providers that are not an LRI.*

A. Proposed Cost Sharing Requirements under the Demonstration as Amended:

This amendment would not change cost sharing requirements. Prior to and after this amendment, there are no premium, enrollment fee, or similar charge, or cost-sharing (including copayments and deductibles) required of individuals enrolled in this demonstration that varies from the State Medicaid Agency's current Medicaid State Plan.

B. Proposed Changes to the Delivery System under the Demonstration as Amended:

The health care delivery system for the provision of services under this demonstration will be implemented in the same manner as under the State Medicaid Agency's current and approved Medicaid State Plan and waivers.

C. Proposed Changes to Benefit Coverage under the Demonstration as Amended:

The benefit coverage will be the same manner as under the State Medicaid Agency's current and approved Medicaid State Plan. Specifically, the coverage criteria and requirements for Personal Care Service (PCS) will continue as they are in State Medicaid Agency's approved State Plan Alternative Benefit Plan (ABP).

D. Proposed Changes to Eligibility Requirements as Amended:

This amendment would not change eligibility requirements. All eligibility requirements will continue to be met through an initial and annual application, review process, and ongoing oversight.

Section III: Expenditure Authority

The State Medicaid Agency is requesting remove the following approved expenditure authority from the demonstration.

2. Use of Legally Responsible Individuals to Render Personal Care Services (PCS). *Expenditures for the state to provide payment for personal care services rendered by legally responsible individuals (which could be inclusive of legally responsible family caregivers), following a reasonable assessment by the state that the caregiver is capable of rendering the services, for beneficiaries eligible to receive 1905(a) personal care services through the Idaho Medicaid state plan providing that the state meets all existing requirements as described under the Medicaid state plan, including Electronic Visit Verification requirements.*

Section IV: Expected Impact on Budget Neutrality

A. Expenditure Projection:

The State Medicaid Agency projects that the total aggregate expenditures under this 1115 Research and Demonstration Waiver demonstration amendment will decrease.

- Services are not being added or deleted to the state Medicaid Program.
- Cost sharing is not changing.
- A provider qualification flexibility is being removed.

Failing to execute the requested amendment will have a material negative impact on the State Medicaid Agency's budget neutrality model for demonstration number 11-W-00339/10.

B. Enrollment Impact:

This amendment should not have an impact on the eligibility or enrollment of Medicaid beneficiaries.

Section V: Evaluation Design

Idaho's 1115 Waiver Evaluation design will not include the removed expenditure authority.

Section VI: Public Notice Process and Input Summary

Pursuant to the terms and conditions that govern Idaho's Demonstration, Idaho must provide documentation of its compliance with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State Medicaid Agency must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act as amended by Section 5006(e) American Recovery and Reinvestment Act of 2009, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan.

Tribal solicitation and public notice were completed by publishing notice and the draft amendment at https://townhall.idaho.gov/. This is an established and well-publicized meeting and information site, created by the Idaho Governor to increase transparency and public involvement.

Tribal solicitation was also completed by sending a Dear Tribal Leader Letter to Tribal representatives.

A summary of all comments received and State Medicaid Agency responses have been included in this application in Appendix A.

STATE MEDICAID AGENCY CONTACT

State Medicaid Director Name: Juliet Charron
Telephone Number: (208) 364-1831
E-mail Address: Juliet.Charron@dhw.idaho.gov

State Lead Contact for Demonstration Application: Charles Beal
Telephone Number: (208) 364-1887
E-mail Address: Charles.Beal@dhw.idaho.gov

Idaho Department of Health and Welfare

APPENDIX A

Public Comments and Responses

Idaho 1115 Demonstration Amendment - FPCS Early Termination Public Comment

Comment Period: November 5th, 2024-December 4th, 2024

220 Total Comments Received

Comment	Idaho Department Health and Welfare Response
Many commenters shared personal stories concerning their family situations and the extent for which they provide care for their child or spouse.	The Department thanks the commenters for sharing their experiences.
220 commenters expressed support for continuation of the 1115 waiver for family personal care services.	The Department thanks the commenters for providing input.
100 commenters expressed concerns regarding the loss of household income or the financial impact the early termination of FPCS will have on their family.	While the Department appreciates the circumstances families find themselves in this service no longer being available, the Medicaid program is not designed to supplement household income or to ensure employment for household members. The purpose of the Medicaid program is to provide coverage for medically necessary services to the Medicaid participant. The Department does not have authority to consider employment needs when making decisions for this program.
156 commenters expressed concern regarding the inability to find a competent caretaker due the direct care worker shortage if FPCS is terminated early.	The Department has actively engaged in marketing and outreach activities to bolster the direct care workforce in Idaho over the past two years and has observed at least a 10% growth in non-legally responsible caregivers. The Department also reminds families who have been caretakers that they are able to continue to provide these services for other community members should they want to continue employment with the PCS provider agencies just not to their loved ones for Medicaid reimbursement. The Department will be available to work with families to find available direct care staff throughout the transition and ongoing.

Comment	Idaho Department Health and Welfare Response
130 commenters expressed concerns that terminating the FPCS program will have a negative impact on their child or spouse/participants served.	Personal Care Services (PCS) will continue to be a benefit for Idaho Medicaid participants. All direct care workers must meet minimum standards intended to provide quality care to participants. Participant preferences are honored to the extent possible in Idaho's home and community-based services. Participant preference cannot override or waive program standards and oversight requirements within the state's current capacity. The Department successfully administered the PCS benefit prior to the COVID 19 pandemic absent LRIs being reimbursed for PCS; this change is reverting back to the pre-pandemic provider qualifications.
127 commenters expressed concerns regarding quality of care and termination of this program. Feedback shared noted that FPCS provides a high quality of patient centered care that is often not received through outside agencies.	All direct care workers must be trained according to minimum standards established by the state. This includes special endorsements, such as using a hoyer lift or other specialized care. If a household has concerns about the training or skills of a direct care staff, they may problem-solve with the agency or report an issue to the Department at http://medicaidcomplaints.dhw.idaho.gov.
123 commenters expressed concerns that the termination of this program will result in their child or spouse having to be institutionalized.	The Department does not expect to see an increase in institutionalization as participants were living in the community before LRIs were reimbursed for providing PCS. The Department will continue to closely monitor trends between institutionalization and community-based services.
118 commenters expressed the program's savings to state costs and increased tax revenue.	Since the program's implementation the Department has seen a 75% increase in participants accessing PCS. Costs have quadrupled and are unsustainable under current appropriations. For the 2025 fiscal year (July through June 2025), $4.2 million was allocated for the program by the legislature. The program costs were $8 million within the first quarter.

Comment	Idaho Department Health and Welfare Response
115 commenters expressed removing FPCS would not suport Idaho's most vulnerable residents.	The Department has actively engaged in marketing and outreach activities to bolster the direct care workforce in Idaho over the past two years and has observed at least a 10% growth in non-legally responsible caregivers. The Department also reminds families who have been caretakers that they are able to continue to provide these services for other community members should they want to continue employment with the PCS provider agencies just not to their children and spouses for Medicaid reimbursement. The Department will be available to work with families to find available direct care staff throughout the transition and ongoing.
15 commenters expressed concerns about strangers providing intimate personal care tasks.	Participant preferences are honored to the extent possible in Idaho's home and community-based services. Participant preference cannot override or waive program standards and oversight requirements within the state's current capacity.
51 commenters expressed that the reason for increase enrollment was due to increased awareness and need. Additionally, the Department should not have authorized any unnecessary enrollment.	Increased enrollment can be attributed to a variety of factors, however, the Department observed parents, spouses, and provider agencies trading tips to exploit the program including: How to maximize authorized hours by manipulating medical assessments; photocopying eligibility paperwork instead of looking for direct care staff; recruiting families outside of Idaho to relocate for services; and advertising the program as a way to make income for families that previously did not need the service. Current Department staff capacity is not sufficient to provide the level of necessary oversight to appropriately mitigate inappropriate service utilization.
30 commenters expressed the numerous benefits they have received from this program.	The purpose of the Medicaid program is to provide coverage for medically necessary services to the Medicaid participant.
12 commenters expressed the need for more support for families.	The Department will share options for the families to provide care for their loved ones.
72 commenters expressed concerns that fraud and abuse could be resolved by adding more robust quality assurance measures and/or stricter eligibility criteria.	The Department has insufficient resources to ensure health and safety and operational integrity for this program due to its exponential growth.

Comment	Idaho Department Health and Welfare Response
16 commenters expressed concerns with finding a caretaker due to being in a rural area.	Families who have been caretakers are able to continue to provide these services for other community members should they want to continue employment with the PCS provider agencies just not to their loved ones for Medicaid reimbursement. Two families in a similiar situtation may provide services for each other. The Department will be available to work with families to find available direct care staff throughout the transition and ongoing.
59 commenters expressed concerns regarding the Department's lack of transparency regarding the FPCS program.	The Department instituted a workgroup in January of 2024 that included advocates, families, and providers. Current information was shared with members for dissemination to their stakeholders. Minutes and agendas were posted to the Department's website for public review.
22 commenters expressed the concern of trusting a caretaker outside of the home.	If households have concerns about the professionalism of direct care staff, they should contact their provider agency. If a household has concerns about the training or skills of a direct care staff, they may problem-solve with the agency or report an issue to the Department at http://medicaidcomplaints.dhw.idaho.gov.
21 commenters expressed concerns that early termination of the FPCS program with result in of disruption to routines, will impact consistency, and have concerns with maintaining stability.	Participant preferences are honored to the extent possible in Idaho's home and community-based services. Participant preference cannot override or waive program standards and oversight requirements within the state's current capacity.
8 commenters expressed that only families/agencies with fraud and abuse should be removed from the program.	The Department has insufficient resources to ensure health and safety and operational integrity for this program due to its exponential growth.
56 commenters stated that there are more families using the program appropriately than those committing fraud.	The Department has insufficient resources to ensure health and safety and operational integrity for this program due to its exponential growth.
7 commenters stated that child was a danger to self and others, and a direct caregiver would not care for them.	The Department will share options for the families to provide care for their loved ones. All direct care workers must be trained according to minimum standards established by the state. This includes special endorsements, such as using a hoyer lift or other specialized care. If a household has concerns about the training or skills of a direct care staff, they may problem-solve with the agency or report an issue to the Department at http://medicaidcomplaints.dhw.idaho.gov.

Comment	Idaho Department Health and Welfare Response
4 commenters expressed they had seen questionable actions by provider agencies and families for FPCS, but the program should be refined and not terminated.	The Department thanks the commenters for their comment.
4 commenters stated their family needs are 24 hours a day, and any other person who worked these types of hours would be paid a fair salary. The families who provide this care for their loved ones deserve some compensation for their hard work.	The Medicaid program is not designed to supplement household income or to ensure employment for household members. The purpose of the Medicaid program is to provide coverage for medically necessary services to the Medicaid participant. The Department does not have authority to consider employment needs when making decisions for this program.
13 commenters stated parents know what's best for their children and should be their caregiver.	The Department thanks the commenters for their comment.
Two commenters suggested the state lower wages or hours for family personal caregivers.	The Department thanks the commenter for their comment.
Two commenters requested fewer hoops for receiving reimbursement.	As a steward of taxpayer funds, the Department must ensure that services are provided with appropriate oversight to ensure quality of care, and the safety of participants.
One commenter expressed distrust in the Department's statistics and analysis and demanded an independent analysis.	The Department thanks the commenter for their comment.
One commenter expressed dissatisfaction that a stepparent will continue to be allowed to provided personal care services but a biological or adopted parent cannot.	Stepparents are not considered legally responsible for their stepchildren. There is no prohibition in 42 CFR 440.167 Personal Care Services on stepparents providing services.
One commenter expressed concerns regarding Idaho discontinuing the Certified Family Home programs.	This amendment is for the 1115 Demonstration regarding Personal Care Services by Legally Responsible Individuals and will have no impact to Certified Family Homes.
Two commenters requests that CMS reject IDHW request to remove FCPS program.	The Department thanks commenters for providing input.
One commenter expressed concerns that removing this program removes participant choice.	Participant preferences are honored to the extent possible in Idaho's home and community-based services. Participant preference cannot override or waive program standards and oversight requirements within the state's current capacity. The prohibition on parents and spouses providing services are in federal regulations at 42 CFR 440.167 Personal Care Services.

Comment	Idaho Department Health and Welfare Response
Two commenters expressed concerns that this program was being terminated for cost savings.	Termination of this program is not due to cost savings for the state. This provider qualification flexibility is ending due to suspected and confirmed health and safety concerns and fraud and abuse since this flexibility has been in place. Further, the Department does not currently have the requisite resources to provide the appropriate level of oversight.
One commenter stated that the state will not see cost savings from terminating this program because the need for care will remain regardless of who provides the services.	Termination of this program is not due to cost savings for the state. This provider qualification flexibility is ending due to suspected and confirmed health and safety concerns and fraud and abuse since this flexibility has been in place. The Department does not currently have the requisite resources to provide the appropriate level of oversight.
Two commenters expressed that amendment fails to identify how it will continue to meet its federal obligations to provide "EPSDT services" and "arrange for" PCS services needed by Idaho Medicaid children after the termination of this program.	The Department is not making any changes to the availability of PCS as required under the EPSDT benefit.
Two commenters expressed that the amendment fails to provide sufficient assurances on how Idaho Medicaid will meet its federal obligation to assist families impacted by this program change and ensure a full continuum of care.	The Department has actively engaged in marketing and outreach activities to bolster the direct care workforce in Idaho over the past two years and has observed at least a 10% growth in non-legally responsible caregivers. The Department also reminds families who have been caretakers that they are able to continue to provide these services for other community members should they want to continue employment with the PCS provider agencies just not to their loved ones for Medicaid reimbursement. The Department will be available to work with families to find available direct care staff throughout the transition and ongoing.
Two commenters expressed that the Amendment Request serves as another example of the Idaho Medicaid's failure to implement a program or service funded by state and federal tax dollars with adequate oversight, staff, and training.	The Department thanks commenters for their comment.
Two commenters expressed concerns that IDHW has demonstrated a pattern or practice of inappropriate program management, oversight, and training which places Idahoans with disabilities, especially children, at risk for inadequate care and treatment, resulting in abuse, neglect, and exploitation.	The Department thanks commenters for their comments and would appreciate additional details regarding these concerns so we may review and follow up.

Idaho Department of Health and Welfare

APPENDIX B

Demonstration Amendment Public Notice

IDAHO DEPARTMENT OF HEALTH & WELFARE

Title:
Division of Medicaid Public Comment Period

Entity:
Department of Health and Welfare

Date/Time:
Nov 5 2024 10:30AM

Category:
Public Hearing

Status:
Published

Add to Calendar

Description
Public Comment Period: 1115 Amendment For Personal Care Services By Legally Responsible Individuals
November 5, 2024, through December 4, 2024.
The draft amendment is posted on the IDHW website at https://healthandwelfare.idaho.gov/about-dhw/policies-procedures-and-waivers (under "Waivers library", PUBLIC-DOCUMENTS > For Providers > Medicaid > Waivers > Idaho 1115 Family personal Care Services Waiver).

It's also attached here.

Virtual Location

Contact Information
Charles Beal
(208) 364-1887
charles.beal@dhw.idaho.gov
https://healthandwelfare.idaho.gov/about-dhw/public-meetings

Physical Location
Entity Main Contact
450 W. State St.
Boise, ID 83702

Google Maps

Documents
11/05/2024 Notice

Recordings

History
11/5/2024 Published

PRESENTED BY: GOVERNOR BRAD LITTLE

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IDAHO DEPARTMENT OF HEALTH & WELFARE

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FAX: (208) 364-1811

November 5, 2024

Dear Tribal Representative:

In accordance with section 1902(a)(73)(A) of the Social Security Act regarding the solicitation of advice prior to the submission of any Medicaid or CHIP State Plan Amendment (SPA) or waiver application or amendment likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations, the Idaho Department of Health and Welfare (IDHW) Division of Medicaid (Idaho Medicaid) provides notice on the following matter.

Purpose

Idaho Medicaid intends to submit an 1115 demonstration amendment to the Centers for Medicare and Medicaid Services (CMS) to remove the following expenditure authority.

> ***2. Use of Legally Responsible Individuals to Render Personal Care Services (PCS).*** *Expenditures for the state to provide payment for personal care services rendered by legally responsible individuals (which could be inclusive of legally responsible family caregivers), following a reasonable assessment by the state that the caregiver is capable of rendering the services, for beneficiaries eligible to receive 1905(a) personal care services through the Idaho Medicaid state plan providing that the state meets all existing requirements as described under the Medicaid state plan, including Electronic Visit Verification requirements.*

These changes are in compliance with 42 C.F.R. Part 431 Subpart G - Section 1115 Demonstrations, as further defined in the CMS approved Standard Terms and Conditions of the state's approved 1115 demonstration.

Proposed Effective Date

The Department intends to submit this amendment to CMS with a requested effective date of January 31, 2025.

Anticipated Impact on Indians/Indian Health Program/Urban Indian Organizations

A. Does this change directly affect American Indians / Alaska Natives (AI/AN) or Indian Health Care Providers (IHCPs) but is federally or statutorily mandated?

This change could affect AI/AN or IHCPs, but is required under federal and state rules regarding safeguarding participants and public monies against fraud, waste, and abuse.

B. Does the change impact services or access to services provided, or contracted for, by Indian Health Care Providers (IHCPs) including but not limited to:
- *Decrease/increase in services*
- *Change in provider qualifications/requirements*
- *Change service eligibility requirements (i.e. prior authorization)*
- *Place compliance costs on Indian Health Care Providers (IHCPs)*
- *Change in reimbursement rate or methodology*

Under IHCPs that are Personal Assistance Agencies, the proposed change adjusts provider qualifications by limiting the ability of certain family members to get paid by Medicaid for providing personal care services to someone they are legally responsible for.

Participants would continue to be eligible for these services, which could continue to be rendered by providers who are not their legally responsible individual. Legally responsible individuals who are now employed by Personal Assistance Agencies may also continue to provide services to participants they are not legally responsible for.

This does not change participant requirements or service eligibility requirements (i.e. prior authorizations). It does not change reimbursement rates or methodology and does not place compliance costs on IHCPs.

C. Does the change negatively impact or change the eligibility for, or access to, American Indians / Alaska Natives (AI/AN) Medicaid?

The proposed changes should not affect Medicaid eligibility or enrollment of American Indians / Alaska Natives (AI/AN).

Availability for Review

The draft amendment will be posted on the IDHW website at https://healthandwelfare.idaho.gov/about-dhw/policies-procedures-and-waivers (under "Waivers library", PUBLIC-DOCUMENTS > For Providers > Medicaid > Waivers > Idaho 1115 Family personal Care Services Waiver). The draft amendment is also attached to this letter.

Comments, Input, and Tribal Concerns

Idaho Medicaid appreciates any input or concerns that Tribal representatives wish to share regarding these changes. Please submit any comments prior to **December 4, 2024,** by email addressed to MCPT@dhw.idaho.gov. This proposed amendment will also be reviewed as part of the Policy Update at the next Quarterly Tribal meeting.

Sincerely,

[redacted]

Juliet Charron
Deputy Director

JC/ah

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
ALEX J. ADAMS – Director

JULIET CHARRON – Deputy Director
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November 6, 2024

MEDICAID INFORMATION RELEASE MA24-28

To: Personal Assistance Agencies

From: Juliet Charron, Deputy Director [redacted]

Subject: Changes To The Family Personal Care Services (FPCS) Program

Due to concerning trends of suspected and confirmed fraud and abuse; significant program growth beyond budget projections; and insufficient staff resources to conduct appropriate oversight, DHW will be terminating the Family Personal Care Services effective January 31, 2025.

The Personal Care Services (PCS) benefit will continue to be available for both children and adults. Qualifying providers will revert to requirements in place prior to the pandemic and legally responsible individuals (parents and spouses) will no longer be able to provide PCS for their family members.

Background

During the public health emergency, CMS allowed a temporary flexibility to decrease the need for direct care workers in people's homes and therefore prevent the spread of COVID-19. The department implemented a temporary flexibility to allow legally responsible parents and spouses to be paid caregivers to their own loved ones who are Medicaid participants with disabilities. This is known as Family Personal Care Services (FPCS). Prior to this flexibility, legally responsible individuals were expressly prohibited in federal and state regulation from being paid personal care aides. Thus, this temporary allowance permitted parents and spouses to be employed by direct care staffing agencies and be paid to work in their homes caring for their loved ones.

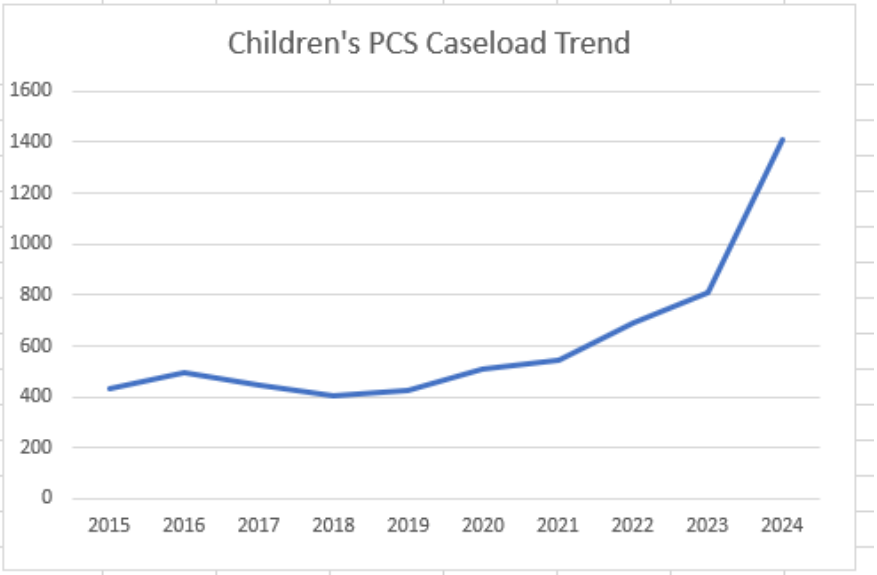
The department extended this flexibility through March 21, 2025, with limited parameters given current staff capacity to oversee the program.

Status

The department has insufficient staff and funding to support this program and its exponential growth and ensure the program's operational integrity.

For many years, there were roughly 500 participants in in children's personal care and private duty nursing services. Enrollment jumped to 546 in 2021, and significantly increased in each subsequent year. We had 1,178 participants in the program in October 2024 and project enrollment at 1,413 by the end of this calendar year, a 75% increase in enrollment since 2023 when the public health emergency ended.

Year	Children's PCS Caseload Trend
2015	434
2016	493
2017	446
2018	402
2019	426
2020	507
2021	546
2022	688
2023	809
2024	1413
	*1,178 as of 10/29/24



This ongoing enrollment surge is due in part to program abuse. We have observed that some parents, spouses, and provider agencies are trading tips on how to seemingly exploit this program, such as:

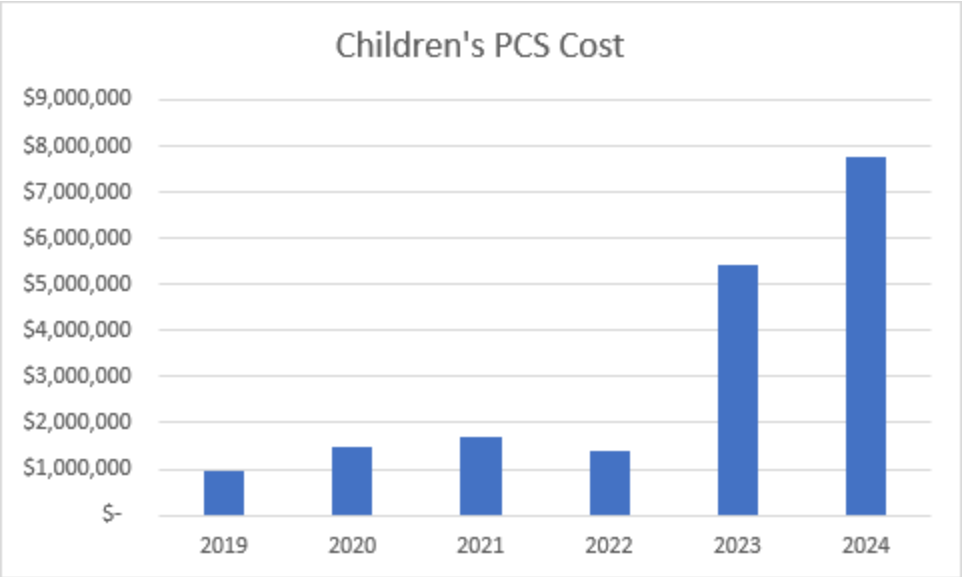
- Sharing information on how to manipulate and respond to the medical assessment in order to maximize authorized hours of service paid by Medicaid.
- Photocopying and sharing eligibility paperwork rather than obtaining independent confirmation from two direct care staffing agencies that they have insufficient staff to serve the child/spouse (as required by the program).
- Recruiting families outside Idaho to move to Idaho to be paid for these services.
- Advertising to employ parents to care for their child(ren) with special needs, saying there is, "No need to work away from home." This incentivizes parents who never previously had a need or interest in these services to apply.
- Communicating the starting pay rates for area provider agencies, resulting in participants switching agencies *not* due to a quality-of-care concern, but exclusively to maximize the household's income.

Other fraudulent and problematic activities include:

- Claiming to care for children but performing other activities at the same time (i.e., driving for Uber).
- Inappropriately double- and triple-billing by caring and billing for multiple children simultaneously (the program only allows a provider to care for one individual at a time). This also presents serious questions of quality and adequacy of care when the child has been identified to need a specific number of hours of care, but it is physically impossible for the parent to serve multiple children for those hours. This includes some parents logging more than 24 hours of care rendered in a day, as confirmed by electronic visit verification (EVV) data.
- Using Medicaid as supplemental household income by determining the needs of the child(ren) on the income received. To quote one mother, "I want PCS for four of my kids. When I find out what my income will be, I might get PCS for [the others]."
- Repeatedly calling department staff to inquire about the status of assessments and actively encouraging others to do the same, taking time away from employees actually completing those assessments and other work for the other Medicaid participants.
- Households that have had continuous Medicaid coverage in the past, but never requested or identified a need for a child (or children) in the household to receive PCS until this flexibility was implemented, with no discernible change in the child's condition that would warrant such a request.
- Instances in which one individual is clocking in and out of services for multiple participants in multiple households that appear to be efforts to avoid detection by quality assurance monitoring of EVV data. In the last calendar quarter, one individual clocked in and out with overlapping visit segments (which is prohibited) for 21 FPCS participants.
- Households selectively providing service hours to attempt to control income that would affect eligibility for other public benefits, which suggests that the child did not medically require the total number of hours authorized.

Not only has enrollment increased, costs have nearly quadrupled since 2022 and are not sustainable within the current appropriation if the program growth continues.[1] We are nearing $8,000,000 spent so far in 2024, with one full quarter remaining in the calendar year. By comparison, the FY 2025 budget authorized by the legislature included just $4,200,000 in anticipated expenditures for FPCS, a difference of 90%.

[1] Medicaid rates changed in summer 2024. The historical costs have been adjusted to account for the change in reimbursement rates.



While expenditures are based on authorized hours of services that are approved by clinical staff, we are aware of many inappropriate attempts to increase the number of authorized hours by families. Further, as described above, the department is aware of significant fraud, waste, and abuse and identified health and safety concerns for participants identified with this program since the benefit was made permanent in late 2023. As stewards of taxpayer dollars and in our role in overseeing this entitlement program serving vulnerable children and adults, we cannot continue to operate a program with such high rates of suspected and known fraud, waste, and abuse potential health and safety issues for participants.

Many of these cases have come to our attention through complaints or observed and experienced interactions with families, content posted on social media, referrals from other state agencies that serve the same population, and referrals by word of mouth from community partners and individual community members. While several of these examples and cases have been referred to the Medicaid Program Integrity Unit, we do not have the infrastructure to administratively identify all cases warranting additional inquiry and pursuit of recovery. Moreover, if fraud is being perpetrated by the household/family, any recovery of funds would be from the agency that the parent/spouse is technically employed by, therein weakening Idaho's already tenuous network of direct care agencies.

The Department recognizes that there are still many families who use this benefit and program appropriately, legitimately need support, and cannot find direct care workers to provide services to their children. The Department has actively engaged in marketing and outreach activities to bolster the direct care workforce in Idaho over the last two years and has observed an approximately 10% growth in the number of unduplicated direct care workers, not including parents and spouses, as identified in the state's Electronic Visit Verification data. The Department will share options through external communications to agencies and families during this transition. Department staff are always available to families and provider agencies to discuss options.

The Bureau of Long Term Care team responsible for administration and oversight of the FPCS program will be implementing additional safeguards and operational processes to provide as much oversight as we are able to during the remaining months of the FPCS flexibility. These activities will include:

- Quarterly supervisory oversight forms submitted by provider agencies will require a narrative to validate that each visit did, in fact, occur and is reflective of adequate clinical oversight.
- Functional assessments for whom the primary respondent is also the direct care worker (including parents and spouses) will be subject to post-processing internal review by the Medical Director to validate that PCS are medically necessary. Additional medical documentation to substantiate the participant's ongoing need for services may be requested.

Processing timeframes for new requests will be moved to 30 days. The team is unable to maintain the current 14-day timeline without detrimental impact to other programs and services administered by these staff. In addition, the Medicaid Program Integrity Unit is actively pursuing recoupments and assessing penalties as appropriate and will refer all credible allegations of fraud to the Medicaid Fraud and Control Unit in the Office of the Attorney General.

Next Steps

CMS has advised the Department that an amendment to the authority currently invoked for this flexibility is necessary to carry out early termination of the program. Early termination will allow the Department to pause enrolling new applicants, and therefore ensure the Legislature has maximum flexibility to determine the appropriate path forward.

The Department will post the draft amendment on Townhall Idaho and send a letter to Idaho Tribes as required. The Department will accept comments for thirty (30) calendar days and send the submission to CMS in early December with a requested effective date of January 31, 2025.

It is our hope that program advocates and participants can work with the Legislature to determine which safeguards are appropriate to resolve the troubling issues we are seeing on the ground, recognizing the need for additional staff capacity if labor-intensive safeguards are selected.

We look forward to working collaboratively with provider agencies, parents and spouses of participants needing personal care services, and other stakeholders to design and implement a sustainable program with integrity deserving of Idahoans' support.

JC

The content of this guidance document is not new law but is an interpretation of existing law prepared by the Idaho Department of Health and Welfare to supply clarity to the public about existing requirements under the law. This document does not bind the public, except as authorized by law or as incorporated into a contract. For additional information or to provide input on this document, contact the Division of Medicaid by emailing MCPT@dhw.idaho.gov or by calling 888-528-5861

PRA Disclosure Statement

PRA Disclosure Statement - The 1115 PMDA application offers a source of high quality and timely data to improve the Center for Medicaid & CHIP Services (CMCS) ability to monitor demonstrations for the achievement of desired outcomes and projected cost savings. The states will upload and submit their budget neutrality workbook to CMCS via PMDA. Eventually PMDA will also be integrated into the Medicaid and CHIP Program (MACPro) System, which currently allows CMS and states to collaborate online to process State Plan Amendments (SPA), 1915 waivers, Quality Measures reports, advance planning documents, and other initiatives. The goal of the PMDA application is to: Collect programmatic quality and other performance metrics, related reports and other information associated with selected 1115 demonstrations; Validate and track performance-based incentive payments for 1115 demonstrations that include them; Provide electronic reports that support CMCS oversight, monitoring and evaluation of 1115 demonstration performance, particularly on quality and other performance metrics, and on related incentive payments (if any); Produce analytic files to support demonstration evaluation. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 CMS-10398 #56. Public burden for all of the collection of information requirements under this control number is estimated to take about 7.5 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Budget neutrality is a Federal policy that governs the Federal expenditures for1115 demonstrations. It is assured by placing an upper limit on the amount of Federal Financial Participation (FFP) the state can receive during the demonstration. The upper limit represents what the state could have received in the absence of the 1115 demonstration.

The Budget Neutrality workbook will assist in collecting standardized data in order to determine financial performance for the demonstration in terms of budget neutrality.

The workbook has two major groups of tabs: the first group collects and calculates Without Waiver (WOW) numbers, and the second group calculates With Waiver (WW) numbers. Data is collected per each demonstration Medicaid Eligibility Group (MEG), by demonstration year (DY). A Medicaid section 1115 demonstration is considered budget neutral if the Federal title XIX match, or funding received by the state (i.e., “with waiver” expenditures) do not exceed what the state would have (or could have) received without the demonstration (i.e., “without waiver” expenditures). The workbook provides the ability to evaluate any variance between WW and WOW calculations.

The workbook consists of 15 tabs which contain different types of data and calculations. The following color schema is applied to the tabs:

Blue	Information populated in the Budget Neutrality workbook template based on the demonstration’s approved STC
Red	Information populated by states on a quarterly basis or per the reporting requirements defined in the STC
Green	Information automatically populated based on the input from other worksheets

Note: Overview and Dropdowns tabs are read-only, no data entry is required. The Dropdowns tab displays the values used to build the dropdowns menus thoroughout the workbook, including the list of active waivers for the demonstration.

Data Entry Within the tabs where a State User populates information (C Report, Total Adjustments, WW Spending Projected, MemMon Actual, MemMon Projected, and Summary TC tabs), yellow highlighted cells denote where data entry may be needed (depending on DY being updated).

Pre-populated values in the downloaded Budget Neutrality workbook template

The original workbook entries are based on the STCs and other demonstration approval documentation. These entries are made on the DY Def, MEG Def, WOW PMPM & Agg, Program Spending Limits, and Summary TC tab (Phase-Down Percentage and Cumulative Target Percentage fields).

The MEG Def tab defines MEGs as Medicaid populations (core demonstration populations), Hypothetical populations (when a demonstration has separate budget neutrality agreements) and Tracking Only populations (for example, "pass-through" populations). The MEG Def tab also defines how expenditure numbers are calculated for a MEG (Per Capita vs. Aggregate) and the applicable scenarios (WOW, WW, or both). Also, the tab contains indicators defining MEG characteristics such as expenditure caps or applicability of savings phase-down calculations.

Calculating With Waiver (WW) numbers

WW numbers for each active DY of a demonstration are calculated based on a combination of actual WW expenditures, projected future expenditures, and any adjustments entered by a State User. The actual WW expenditures are copied from the Schedule C of the MBES CMS-64 report to the workbook (C Report tab). These numbers are automatically transferred to the C Report Grouper tab, where waiver expenditures are grouped by MEGs. The numbers are also transferred to the WW Spending Actual tab, which factors in adjustments entered on the Total Adjustments tab to calculate total actual WW expenditures. The WW Spending Total tab displays the actual WW expenditures plus future projected expenditures (transferred from the WW Spending Projected tab). Finally, the total WW actual and projected numbers are transferred to the Summary TC (Total Computable) tab (into the With-Waiver Total Expenditures section).

Calculating Without Waiver (WOW) numbers

WOW numbers can be obtained either one of two ways: using Aggregate or Per Capita calculations. If total projected expenditures for a MEG is known and the expenditure calculation type is defined as 'Aggregate' on the MEG Def tab, the total projected expenditure amount is entered for each active DY. However, if the expenditure calculation type is defined as 'Per Capita', total projected expenditures are derived by multiplying per member per month (PMPM) costs by the actual number of member months.

Both Aggregate and PMPM numbers are populated on the WOW PMPM & Agg tab. The number of actual member months (number of beneficiaries times the number of months enrolled) are entered by a State User on the MemMon Actual tab for each DY. On the MemMon Projected tab, State User enters projected numbers. The totals for actual and projected member months are calculated on the MemMon Total tab. WOW aggregate, PMPM and member month data is then moved to the the Without-Waiver Total Expenditures section of the Summary TC tab, where final calculations are performed.

Based on information from all tabs, the WW and WOW numbers are compared to determine the budget neutrality status of the demonstration.

Below are the definitions for the tabs of the workbook which require data entries from State User.

On top of the C Report tab, enter data in the following highlighted cells:

‘Data Pulled On:’ - enter the date the source file used to enter data on this tab was pulled
‘For the Time Period Through :’ - enter the date through which the source file data was pulled
Reporting DY' - enter the Demonstration Year (DY) for which data is being reported. Entered DY value must align with DYs from the DY Def tab.
Reporting Quarter' - enter a number of the quarter (values 1 through 4) for which data is being reported.

Notes:

- Dates must be entered in the following format: mm/dd/yyyy
- Reporting DY and Reporting Quarter entries affect which portion of the 'Medicaid Aggregate' and 'Medicaid Aggregate - WOW only' amounts for a DY will be calculated as Actuals, and which will be calculated as Projected
- Entry for each of these four fields is required for the workbook submission. If any field is not populated, you will receive an error and the document will not be uploaded to the system.

State User enters information on the following tabs:

C Report Tab

Open Schedule C of the CMS 64 Expenditure Report. Under your state, locate expenditure data for the specific demonstration.
From this location on the CMS 64 Expenditure Report, copy expenditure data cells for all DYs (active and non-active). On the C Report tab, paste the data into the correct cell/row. Repeat the copy and paste process for MAP Waivers section (Total Computable and Federal Share) and ADM Waivers section (if applicable). Verify that the pasted numbers are correctly aligned with the Waiver Name values.

Total Adjustments tab

When adjustments are relevant for a demonstration, enter the actual numbers of total contributions to the reported expenditures, per each MEG, for the reporting quarter. Add new reported adjustments to any existing numbers for previous quarters for the reported DY.
Note: Any adjustments that reduce expenditures must be entered as negative numbers (for example, -$10,000).

WW Spending Projected tab

Enter projected annual expenditures for each MEG for the active DYs of a demonstration.
For each reporting quarter, update the projected numbers so they reflect only future quarter projections. Please see the example for the MemMon Projected tab.

MemMonth Actual tab

For each MEG, calculate the actual number of member months for the reported quarter and add this number to the previously entered number for the same DY. For example, for Q3 reporting period, add Q3 member months to the existing number for the same MEG and DY and enter the result into the same cell.

MemMonth Projected tab

For each MEG, enter projected (future) annual member months for all active DYs of the demonstration. Adjust future DY numbers as needed.
For the current DY, enter only the number that reflects future quarters. For example, for Q3 reporting, only enter the projected number for Q4. There should be no projected numbers for completed (actual) DYs.

Summary TC tab

In the Net Variance section, for each DY, enter estimated numbers in row '1115A Dual Demonstration Savings (state preliminary estimate)'.
In the next row, '1115A Dual Demonstration Savings (OACT certified)' enter certified numbers.
Both estimated and certified numbers must be negative, as dual demonstration savings numbers reduce the Net Variance amount.

Demonstration Years Definitions

DY	1	2	3	4	5
Start Date	4/17/2020	4/1/2021	4/1/2023	4/1/2023	4/1/2024
End Date	3/31/2021	3/31/2022	3/31/2023	3/31/2024	3/31/2025

Enter any general comments / notes:

MEG Definitions

	MEG Name	MEG Description	Savings Phase-Down	Expenditures Subject to Cap?	Hypothetical Populations Included in Calculations?	Start DY	Start Date	End DY	End Date
	Hypothetical 1 Per Capita				Hypothetical Test 1				
1	FFS- SMI/SED	Medicaid beneficiaries diagnosed with a SMI/SED in fee-for-service	N/A	No	Yes	*1*	*4/17/2020*	*5*	*3/31/2025*
2	FFS- SUD	Medicaid beneficiaries diagnosed with a SUD in fee-for-service	N/A	No	Yes	*1*	*4/17/2020*	*5*	*3/31/2025*

WOW PMPMs and Aggregates

		DEMONSTRATION YEARS (DY)				
		1	2	3	4	5
Hypothetical 1 Per Capita						
FFS- SMI/SED	1	$8,590.00	$8,968.00	$9,363.00	$9,775.00	$10,205.00
FFS- SUD	2	$6,889.00	$7,193.00	$7,509.00	$7,839.00	$8,184.00

Program Spending Limits

	Cap Amounts per Demonstration Year					TOTAL
Program Name and Associated MEGs	**1**	**2**	**3**	**4**	**5**	
Spending Cap						
						$ -
Expenditures Subject to Cap						
Variance						$ -
Over or Under	.	.	.	.	.	.

Data Pulled On:	8/16/2023	**Reporting DY**	4
For the Time Period Through:	6/30/2023	**Reporting Quarter**	1

Paste all information related to the demonstration from Schedule C of the CMS 64 Waiver Expenditure Report.
1. On the Schedule C Report, locate rows relevant to all expenditures for a specific demonstration.
2. Complete two rounds of copy/paste starting from the cell in column A (Waiver Name).
- MAP Waivers/ Total Computable section – into cell A100
- MAP Waivers/ Federal Share section – into cell A200

3. If ADM waivers are applicable to the demonstration, complete two more rounds of copy/paste starting from the cell in column A (Waiver Name).
- ADM Waivers/ Total Computable section – cell A300
- ADM Waivers/ Federal Share section – cell A400

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
SMI/SED	0	10,316,442	14,587,204	16,575,762	3,830,969	0	0	0	0	0	0	0	0	0	0	0	0	0
SUD	0	2,994,954	757,699	884,487	322,592	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**13,311,396**	**15,344,903**	**17,460,249**	**4,153,561**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
SMI/SED	0	8,686,569	12,318,741	14,128,313	3,267,416	0	0	0	0	0	0	0	0	0	0	0	0	0
SUD	0	2,635,766	661,874	774,938	283,343	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**11,322,335**	**12,980,615**	**14,903,251**	**3,550,759**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
0	0	0	0	0	0	0	0	0	0	0	0	0	6,713,137	6,713,137
0	0	0	0	0	0	0	0	0	0	0	0	0	2,177,358	2,177,358
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8,890,495**	**8,890,495**

18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
0	0	0	0	0	0	0	0	0	0	0	0	0	5,140,200	5,140,200
0	0	0	0	0	0	0	0	0	0	0	0	0	1,667,100	1,667,100
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**6,807,300**	**6,807,300**

C Report Grouper

MAP Waivers Only

Total Computable

MEG Names		C Report Waiver Names	DEMONSTRATION YEARS (DY) 1	2	3	4	5
Hypothetical 1 Per Capita							
FFS- SMI/SED	1	SMI/SED	$10,316,442	$14,587,204	$16,575,762	$3,830,969	
FFS- SUD	2	SUD	$2,994,954	$757,699	$884,487	$322,592	
TOTAL			$ 13,311,396	$ 15,344,903	$ 17,460,249	$ 4,153,561	$ -

Adjustments made to the reported expenditures

Enter total adjustments made to the expenditure numbers, including adjustments to the previous reporting periods.
Positive adjustments increase expenditures, and negative adjustments decrease expenditures.
Enter adjustments for every MEG for which adjustments were made or are planned.
Helpful Hint: Remember to enter total adjustments as positive or negative (for example, -$10,000 reflects a decrease in expenditures).

		DEMONSTRATION YEARS (DY) 1	2	3	4	5	Description (type of collection, time period, CMS-64 reporting line, etc.)
Hypothetical 1 Per Capita							
FFS- SMI/SED	1	$2,878,991	$390,688	$291,133	-$486,775		Adjustment reflect moving the claims from a paid basis in the Schedule C Report to an incurred basis. Additionally, the totals in this workbook include paid run out through 7/25/2023 where the Schedule C Report has claims paid through 6/30/2023.
FFS- SUD	2	$199,552	-$201,279	$75,652	$27,100		Adjustment reflect moving the claims from a paid basis in the Schedule C Report to an incurred basis. Additionally, the totals in this workbook include paid run out through 7/25/2023 where the Schedule C Report has claims paid through 6/30/2023.

WW Spending - Actual

Total Computable

		DEMONSTRATION YEARS (DY)				
		1	2	3	4	5
Hypothetical 1 Per Capita						
FFS- SMI/SED	1	$13,195,433	$14,977,892	$16,866,895	$3,344,194	
FFS- SUD	2	$3,194,506	$556,420	$960,139	$349,692	
TOTAL		**$ 16,389,939**	**$ 15,534,312**	**$ 17,827,034**	**$ 3,693,886**	**$ -**

WW Spending - Projected

Enter projected spending for the demonstration which includes the remaining quarters of the current DY and all future DYs.
Enter the projected annual expenditures for each DY per MEG for the active DYs.
For the current DY, only future quarters should have projected spending information. Do not include expenditures that were reported as actuals.

Total Computable

		DEMONSTRATION YEARS (DY)				
		1	2	3	4	5
Hypothetical 1 Per Capita						
FFS- SMI/SED	1				$21,451,822	$30,000,673
FFS- SUD	2				$2,916,108	$4,465,190

WW Spending - Total

Total Computable

		DEMONSTRATION YEARS (DY) 1	2	3	4	5
Hypothetical 1 Per Capita						
FFS- SMI/SED	1	$13,195,433	$14,977,892	$16,866,895	$24,796,016	$30,000,673
FFS- SUD	2	$3,194,506	$556,420	$960,139	$3,265,800	$4,465,190
TOTAL		**$ 16,389,939**	**$ 15,534,312**	**$ 17,827,034**	**$ 28,061,816**	**$ 34,465,863**

Member Months - Actual

Enter actual member months (number of beneficiaries times the number of enrolled months) for quarters to date for each active DY.
For the reported quarter, add the actual number of member months per each MEG to the previous actual number. The number should equal the total of ALL actual member months.
Note: Depending of the specifics of the state, you can use Total member months or Average monthly unduplicated counts. Whichever definition is used, it must be applied consistently.
Helpful Hint: When updating a DY, remember to enter actual member months for the reported quarter along with actuals for prior quarter(s). Retroactive adjustments may affect the entries.

		DEMONSTRATION YEARS (DY)				
		1	2	3	4	5
Hypothetical 1 Per Capita						
FFS- SMI/SED	1	2456	2556	2687	616	
FFS- SUD	2	685	235	372	124	

Member Months - Projected

Enter/adjust projected member months based on reported actuals.
Enter projected number of member months for each active DY per MEG for the demonstration.
For the current DY, enter only the number that reflects projections for future quarters of the DY.
Do not include member months for either the current reporting quarter or past quarters.

		DEMONSTRATION YEARS (DY)				
		1	**2**	**3**	**4**	**5**
Hypothetical 1 Per Capita						
FFS- SMI/SED	1				2195	2940
FFS- SUD	2				372	546

Member Months - Total

		DEMONSTRATION YEARS (DY)				
		1	2	3	4	5
Hypothetical 1 Per Capita						
FFS- SMI/SED	1	2,456	2,556	2,687	2,811	2,940
FFS- SUD	2	685	235	372	496	546

Budget Neutrality Summary

The Budget Neutrality Reporting Period dropdown menu allows for selection of a specific reporting period, by Demonstration Year.
By changing these settings, you change the view for which Demonstration Years will be used in calculating Budget Neutrality.
Selecting the 'Reset to Defaults' button will reset the Reporting DY values back to the demonstration's current Period of Performance.

Budget Neutrality Reporting Start DY	**1**
Budget Neutrality Reporting End DY	**5**

Actuals + Projected

BASE VARIANCE			$ -	$ -	$ -	$ -	$ -	$ -
Excess Spending from Hypotheticals								$ -
1115A Dual Demonstration Savings (state preliminary estimate)								$ -
1115A Dual Demonstration Savings (OACT certified)								$ -
Carry-Forward Savings From Prior Period								
NET VARIANCE								$ -

HYPOTHETICALS TEST 1

Without-Waiver Total Expenditures

			DEMONSTRATION YEARS (DY) 1	2	3	4	5	TOTAL
Hypothetical 1 Per Capita								
FFS- SMI/SED	1	**Total**	$ 21,097,040	$ 22,922,208	$ 25,158,381	$ 27,473,222	$ 30,000,673	
		PMPM	$8,590.00	$8,968.00	$9,363.00	$9,775.00	$10,205.00	
		Mem-Mon	2,456	2,556	2,687	2,811	2,940	
FFS- SUD	2	**Total**	$ 4,718,965	$ 1,690,355	$ 2,793,348	$ 3,888,144	$ 4,465,190	
		PMPM	$6,889.00	$7,193.00	$7,509.00	$7,839.00	$8,184.00	
		Mem-Mon	685	235	372	496	546	
TOTAL			**$25,816,005**	**$24,612,563**	**$27,951,729**	**$31,361,366**	**$34,465,863**	**$144,207,526**

With-Waiver Total Expenditures

			DEMONSTRATION YEARS (DY) 1	2	3	4	5	TOTAL
Hypothetical 1 Per Capita								
FFS- SMI/SED	1		$13,195,433	$14,977,892	$16,866,895	$24,796,016	$30,000,673	
FFS- SUD	2		$3,194,506	$556,420	$960,139	$3,265,800	$4,465,190	
TOTAL			**$ 16,389,939**	**$ 15,534,312**	**$ 17,827,034**	**$ 28,061,816**	**$ 34,465,863**	**$ 112,278,964**

HYPOTHETICALS VARIANCE 1			**$ 9,426,066**	**$ 9,078,251**	**$ 10,124,695**	**$ 3,299,550**	**$ -**	**$ 31,928,562**

HYPOTHETICALS TEST 1 Cumulative Target Limit

			DEMONSTRATION YEARS (DY) 1	2	3	4	5	
Cumulative Target Percentage (CTP)			2.0%	1.5%	1.0%	0.5%		
Cumulative Budget Neutrality Limit (CBNL)			$ 25,816,005	$ 50,428,568	$ 78,380,297	$ 109,741,663	$ 144,207,526	
Allowed Cumulative Variance (= CTP X CBNL)			$ 516,320	$ 756,429	$ 783,803	$ 548,708	$ -	
Actual Cumulative Variance (Positive = Overspending)			$ (9,426,066)	$ (18,504,317)	$ (28,629,012)	$ (31,928,562)	$ (31,928,562)	
Is a Corrective Action Plan needed?								

Yes No
Yes
No

Per Capita or Aggregate
Per Capita
Aggregate

Phase-Down
No Phase-Down
Savings Phase-Down

Actuals and Projected
Actuals Only
Actuals + Projected

MAP_ADM
MAP+ADM Waivers
MAP Waivers Only

Waiver List
MAP WAIVERS
Not Applicable
SMI/SED
SUD
ADM WAIVERS

Demonstration Reporting Start DY	1
Demonstration Reporting End DY	5

Reporting Net Variance

$ -