IDAPA 16 – IDAHO DEPARTMENT OF HEALTH AND WELFARE

Division of Medicaid

16.03.13 – Consumer-Directed Services

Who does this rule apply to?
For those seeking to participate in the Consumer-Directed Community Supports (CDCS) program under Idaho Medicaid.

What is the purpose of this rule?
This chapter of rules contains the provisions for administering Consumer-Directed Community Supports (CDCS), a flexible program option for participants eligible for the Children's Home and Community Based Services (HCBS) State Plan Option, and Adult and Children's Developmental Disabilities (DD) waivers. CDCS is not a covered option for participants enrolled in the Children's Act Early Waiver. The CDCS option allows the eligible participant to: choose the type and frequency of supports they want, negotiate the rate of payment, and hire the person or agency they prefer to provide those supports.

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

Public Assistance and Welfare -
Public Assistance Law:
- Section 56-202(b), Idaho Code – Duties of Director of State Department of Health & Welfare
- Section 56-203, Idaho Code – Powers of the State Department
- Section 56-253, Idaho Code – Powers and Duties of the Director
- Section 56-264, Idaho Code – Rulemaking Authority

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

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

Who do I contact for more information on this rule?

Idaho Department of Health and Welfare
Division of Medicaid – Consumer Directed Services
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Boise, ID 83702

P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5747, 1-877-200-5441 (toll free), or 1-866-702-5212 (toll free)
Fax: (208) 364-1811
Email: Medicaid.Rules@dhw.idaho.gov
Bureau of Developmental Disabilities Adult Care Management: BDDACM@dhw.idaho.gov
Webpages: Medicaid: https://medicaid.idaho.gov and Self-Direction:
https://healthandwelfare.idaho.gov/services-programs/medicaid-health/self-directed-services

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000. LEGAL AUTHORITY.
Sections 56-202, 56-203, Sections 56-250 through 257, and Sections 56-260 through 56-266, Idaho Code. (7-1-25)

001. SCOPE.
Consumer-Directed Community Supports (CDCS) is a flexible program option for participants eligible for the Children's Home and Community Based Services (HCBS) State Plan Option, and Adult and Children's Developmental Disabilities (DD) waivers. CDCS is not a covered option for participants enrolled in the Children's Act Early Waiver. The CDCS option allows the eligible participant to: choose the type and frequency of supports they want, negotiate the rate of payment, and hire the person or agency they prefer to provide those supports. (3-17-22)

002. -- 008. (RESERVED)

009. BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Background Check. The FEA must verify that each SB and CSW has received a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." A participant may choose to waive the background check requirement for a CSW. A waiver must be completed under these rules. (7-1-25)

02. Availability to Work or Provide Service. Participants may review the completed application and allow the CSW to provide services on a provisional basis if no disqualifying offenses under IDAPA 16.05.06, "Criminal History and Background Checks," are disclosed. (7-1-25)

03. Additional Convictions, Investigations, or Charges. Once clearances have been received, any additional criminal, adult or child protection convictions, charges or investigations, must be immediately reported by the worker to the participant and by the participant to the Department. (7-1-25)

04. Providers Subject to Background Check Requirements. CSWs who have not had the requirement waived by the participant and SBs. (7-1-25)

010. DEFINITIONS.

01. Community Support Worker (CSW). An individual, agency, or vendor selected and paid by the participant to provide CSW services. (7-1-25)

02. Consumer-Directed Community Supports (CDCS). A flexible program option for participants eligible for the Children's Home and Community Based Services (HCBS) State Plan Option, and Adult Developmental Disabilities (DD) waiver. Supports include SDCS and FDCS program options described in IDAPA 16.03.10. "Medicaid Enhanced Plan Benefits." (7-1-25)

03. Family-Directed Community Supports (FDCS). A program option for children eligible for Children's HCBS State Plan Option described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-25)

04. Financial Management Services (FMS). Services provided by an FEA. (7-1-25)

05. Fiscal Employer Agent (FEA). An agency that provides FMS to participants who have chosen the CDCS option. FEA is selected by the participant. (7-1-25)

06. Goods. Tangible products or merchandise that are authorized on the SSP. (7-1-25)

07. Guiding Principles for the CDCS Option. (7-1-25)

a. Freedom for the participant to make choices and plan their own life; (3-17-22)

b. Authority for the participant to control resources allocated to them to acquire needed supports; (3-17-22)

c. Opportunity for the participant to choose their own supports; (3-17-22)

d. Responsibility for the participant to make choices and take responsibility for the result of those

choices; and (3-17-22)

e. Shared responsibility between the participant and their community to help the participant become an involved and contributing member of that community. (3-17-22)

08. Home and Community Based Services (HCBS). Long-term services and supports that assist participants to remain in their home and community. (7-1-25)

09. Medical Necessity (Medically Necessary). A service or item is medically necessary if: (7-1-25)

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; (7-1-25)

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service that is more conservative or substantially less costly; and (7-1-25)

c. It meets any applicable Department criteria. Services that do not meet criteria require a prior authorization; and (7-1-25)

d. Medical services must be: (7-1-25)

i. Of a quality that meets professionally recognized standards of health care; and (7-1-25)

ii. Substantiated by records including evidence of such medical necessity and quality. (7-1-25)

10. Readiness Review. A review conducted by the Department to ensure that each FEA is prepared to enter into and comply with the requirements of the provider agreement and this chapter of rules. (7-1-25)

11. Restrictive Intervention. Any intervention that is used to restrict the rights or freedom of movement of a person and includes chemical, mechanical, and physical restraints or seclusion. (7-1-25)

12. Self-Directed Community Supports (SDCS). A program option for adults eligible for the Adult DD Waiver described in IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits.” (7-1-25)

13. Support and Spending Plan (SSP). A document that functions as a participant’s plan of care when the participant is eligible for and has chosen a CDCS option. This document identifies the goods, services, and supports selected by a participant, including those available outside of Medicaid-funded services that can help the participant meet desired goals, and the cost of each one. The participant uses this document to manage their individualized budget. (7-1-25)

14. Supports. Services provided for a participant, or a person who provides a support service. A support service may be a paid service provided by a CSW, or an unpaid service provided by a natural support, such as a family member, a friend, neighbor, or other volunteer. (7-1-25)

15. Support Broker (SB). An individual who advocates on behalf of the participant and who is hired by the participant to provide SB services. (7-1-25)

16. Traditional Adult DD Waiver Services. A program option for participants eligible for the Adult DD Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits.” (7-1-25)

17. Traditional Children's HCBS State Plan Option Services. A program option for children eligible for the Children's HCBS State Plan Option consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits.” (7-1-25)

011. -- 100. (RESERVED)

101. PARTICIPANT ELIGIBILITY.

01. Eligibility Determination. In order to choose the CDCS option, the participant must first be determined Medicaid-eligible and determined to meet existing Adult DD waiver or Children's HCBS State Plan Option requirements as outlined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-25)

02. Participant Agreement. The participant, if able, and their legal representative, if one exists, must agree in writing using a Department-approved form to the following: (7-1-25)

a. Accept the guiding principles for the CDCS option, as defined in these rules; (7-1-25)

b. Agree to meet the participant responsibilities outlined in these rules; (7-1-25)

c. Take responsibility for and accept potential risks, and any resulting consequences, for their support choices. If the participant is unable to give consent, this falls to their legal representative; and (7-1-25)

d. Acknowledge and follow the applicable HCBS rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-25)

03. Participants involuntarily removed from the CDCS option will be ineligible for this option for a period of five years. Re-application will be reviewed on a case-by-case basis and will include consideration of the previous conditions for removal. (7-1-25)

102. -- 109. (RESERVED)

110. PAID CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS).
Participants must purchase FMS and SB services to participate in the CDCS option. Participants must purchase goods and community supports through an FEA who is providing the FMS. (7-1-25)

01. FMS. The Department will enter into a provider agreement with qualified FEAs, as defined in these rules, to provide FMS for payroll and reporting functions to participants who choose the CDCS option. (7-1-25)

02. SB Services. Services provided by a qualified SB to assist in making informed choices, participate in a person-centered planning process, and become skilled at managing their own supports such as negotiating and budgeting. SBs have to apply for requalification annually. (7-1-25)

03. CSW Services. The CSWs provide identified supports to the participant. If the identified support requires specific licensing or certification within the state of Idaho, the identified CSW must obtain the applicable license or certification. Identified supports include activities that address the participant's preference in both FDCS and SDCS, unless otherwise specified, for: (7-1-25)

a. Job support for SDCS to help the participant secure and maintain employment or attain job advancement; (7-1-25)

b. Personal support to help the participant maintain health, safety, and basic quality of life; (3-17-22)

c. Relationship support to help the participant establish and maintain positive relationships with immediate family members, friends, spouse, or others in order to build a natural support network and community; (3-17-22)

d. Emotional support to help the participant learn and practice behaviors consistent with their goals and wishes while minimizing interfering behaviors; (3-17-22)

e. Learning support for SDCS to help the participant learn new skills or improve existing skills that relate to their identified goals; (7-1-25)

f. Transportation support to help the participant accomplish their identified goals; and (7-1-25)

g. Skilled nursing support for SDCS identified in the participant's plan that is within the scope of the Nurse Practice Act and is provided by a licensed registered nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho. (7-1-25)

04. Medically Necessary Equipment. Adaptive and therapeutic equipment is medically necessary, meets a medical or accessibility need, and promotes increased independence. FDCS may substitute medical necessity for minimizing the participant's need for institutionalization. Items may be covered when: (7-1-25)

a. Not available through another source; (7-1-25)

b. Identified in the participant's plan; (7-1-25)

c. Safe and effective treatment that meets evidence – based treatment criteria; (7-1-25)

d. Optimal for the participant's health, safety and welfare; (7-1-25)

e. Least costly alternative that reasonably meets the identified need; (7-1-25)

f. For the sole benefit of the participant; and (7-1-25)

g. Meets at lease one (1) of the following: (7-1-25)

i. Assist the ability of the participant to remain in the community; (7-1-25)

ii. Enhance community inclusion and family involvement; and (7-1-25)

iii. Decrease dependency on formal support services. (7-1-25)

05. Limitations. Services have the following limitations: (7-1-25)

a. CDCS Purchased items and services must meet needs related to a developmental disability diagnosis. The use of CDCS and FDCS purchased items by an individual other than the participant is prohibited. The following types of items or services are not covered: (7-1-25)

i. For the convenience of a caregiver; (7-1-25)

ii. Educational; (7-1-25)

iii. Recreational; or (7-1-25)

iv. Vocational except pre-vocational and job supports. (7-1-25)

b. CDCS services may only be rendered by (1) staff to one (1) participant at a time. Staff may not: (7-1-25)

i. Render any other support, service, or supervision, paid or unpaid, to any other individual; or (7-1-25)

ii. Perform multiple services concurrently. (7-1-25)

c. CDCS and FDCS transportation support is limited to one thousand eight hundred (1,800) miles annually, unless otherwise authorized. (7-1-25)

111. UNPAID COMMUNITY SUPPORTS AND SERVICES.

The Department requires that participants and their SB identify and prioritize the use of any goods, services and

supports available outside of Medicaid-funded services that can be provided by an unpaid natural support such as a family member, a friend, a neighbor or other volunteer. (7-1-25)

112. -- 119. (RESERVED)

120. PARTICIPANT RESPONSIBILITIES.
With the assistance of the SB, and the legal representative, if one exists, the participant is responsible for the following: (7-1-25)

01. Guiding Principles. Accepting and honoring the guiding principles for the CDCS option defined in these rules. (7-1-25)

02. Person-Centered Planning. Directing the person-centered planning process in order to identify and document paid and unpaid support and service needs, wants, and preferences. (3-17-22)

03. Rates. Negotiating payment rates for all paid community supports they want to purchase. They must also ensure rates negotiated for supports and services do not exceed the prevailing market rate, are cost-effective when comparing them to reasonable alternatives, and include the details in the employment agreements. (7-1-25)

04. Agreements. Completing and implementing agreements for the FEA, the SB and CSWs, and submitting the agreements to the FEA. These agreements must be submitted on Department-approved forms and must specifically identify the type of support being purchased, the rate negotiated for the support, and the frequency and duration of the scheduled support or service. The participant is responsible for ensuring that each employment agreement; clearly identifies the qualifications needed to provide the support or services; includes a statement signed by the hired worker that they possess the needed skills; and the signature of the participant that verifies the same. Additionally, each employment agreement will include statements that; the participant is the employer even though payment comes from a third party; employees are under the direction and control of the participant; services must be delivered consistent with the HCBS rules in IDAPA 16.03.10. "Medicaid Enhanced Plan Benefits;" and no employer-related claims will be filed against the Department. (7-1-25)

05. SSP. Developing a comprehensive SSP, based on the information gathered during person-centered planning. (7-1-25)

06. Time Sheets and Invoices. Reviewing and verifying that goods and services being billed were provided and indicating that they approve of the bill by signing the timesheet or invoice. (7-1-25)

07. Quality Assurance and Improvement. Providing feedback to the best of their ability regarding their satisfaction with the goods and services they receive and the performance of their workers. (7-1-25)

08. Sufficient Staffing. Hiring enough CSWs to ensure services are rendered in a manner for the health and safety of the participant. (7-1-25)

09. Required Classes. The participant must attend classes on Guide Training by the Department and FEA Training, (7-1-25)

121. -- 134. (RESERVED)

135. SUPPORT BROKER (SB) REQUIREMENTS AND LIMITATIONS.

01. SB Requirements. Individuals interested in becoming an SB must: (7-1-25)

a. Be eighteen (18) years of age or older; (7-1-25)

b. Have skills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field; and (7-1-24)

c. Have at least two (2) years verifiable experience with the target population and (7-1-25)

d. Knowledge of services and resources in the developmental disabilities field. (7-1-25)

02. Application Exam. Applicants that meet the minimum requirements under this rule will receive training materials and resources to prepare for the application exam. Under FDCS, children's SBs must attend an initial training. Applicants must earn a score of seventy percent (70%) or higher to pass. Applicants may take the exam up to three (3) times. After the third time, the applicant will not be allowed to retest for twelve (12) months from the date of the last exam. Applicants who pass the exam, and meet all other requirements under these rules, will be eligible to enter into a Medicaid Support Broker Agreement with the Department. (7-1-25)

03. Required Ongoing Training. All SBs must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of SB services. Up to six (6) hours may be obtained through independent self-study. The remaining hours must consist of classroom training. (7-1-25)

04. Termination. The Department may terminate the Medicaid Support Broker Agreement in accordance with Idaho Code 56-209h(6) or when the SB: (7-1-25)

a. Is no longer able to pass a background check under these rules. (7-1-25)

b. Puts the health or safety of the participant at risk by failing to perform job duties under the employment agreement. (7-1-24)

c. Does not receive and document the required ongoing training and requalification. (7-1-25)

05. Limitations. The SB must: (7-1-25)

a. Not provide, or be employed by an agency that provides CSW services to the same participant; and (7-1-25)

b. For SDCS, meet the conflict of interest standards under IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits.” (7-1-25)

c. SBs are limited to reimbursement for three thousand one hundred twenty (3,120) hours per calendar year across all participants served unless otherwise authorized by the Department. (7-1-25)

06. Time Sheets and Invoices. SBs must submit accurate time sheets and invoices for reimbursement or be subject to recoupment. (7-1-25)

136. SUPPORT BROKER (SB) DUTIES AND RESPONSIBILITIES.

01. Initial Documentation. Prior to beginning employment for the participant, the SB must type and complete and submit to the participant, the packet of information provided by the FEA. This packet must include documentation of: (7-1-25)

a. SB application approval by the Department; (7-1-25)

b. A completed background check, including clearance in accordance with of these rules and IDAPA 16.05.06, “Criminal History and Background Checks”; and (7-1-25)

c. A completed employment agreement in accordance with these rules. The negotiated rate must not exceed the maximum hourly rate for SB services established by the Department. (7-1-25)

02. Documentation. SB must complete all documentation required by the Department including documentation of the date and type of service provided and billed for. All documentation for services will be retained by the SB for five (5) years. (7-1-25)

03. Required Duties. SB services may include only a few required tasks or may be provided as a

comprehensive service package depending on the participant's needs and preferences. At a minimum, the SB must: (7-1-25)

a. Assist in facilitating the person-centered planning process as directed by the participant and consistent with the HCBS rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits;" (7-1-25)

b. Develop a written SSP with the participant that includes the paid and unpaid supports that 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 (3) backup plans should a support fail. The SSP must be authorized by the Department; (7-1-25)

c. Assist the participant to monitor and review their budget; (3-17-22)

d. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department; (3-17-22)

e. Adhere to Department quality assurance measures; (7-1-25)

f. Assist the participant to complete the annual re-determination process as needed, including updating the SSP and submitting it to the Department for authorization; (7-1-25)

g. Assist the participant, as needed, to meet the participant responsibilities outlined in these rules and assist the participant, as needed, to protect their own health and safety; (7-1-25)

h. Complete the Department-approved background check waiver form when a participant chooses to waive the background check requirement for a CSW. Completion of this form requires that the SB provide education and counseling to the participant and their COS regarding the risks of waiving a background check and assist with detailing the rationale for waiving the background check and how health and safety will be protected; (7-1-25)

i. Assist children enrolled in the FDCS option as they transition to adult DD services. (7-1-25)

j. Sign the written SSP as required in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits,"; and (7-1-25)

k. Report concerns or discrepancies in documentation and services provided to the Department immediately. (7-1-25)

04. Additional Duties. In addition to the required SB duties, each SB must be able to provide the following services when requested by the participant: (7-1-25)

a. Assist the participant to develop and maintain a COS; (7-1-25)

b. Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports; (3-17-22)

c. Assist the participant to negotiate rates for paid CSW; (7-1-25)

d. Maintain documentation of supports provided by each CSW and participant's satisfaction with these supports; (7-1-25)

e. Assist the participant to monitor community supports; (3-17-22)

f. Assist the participant to resolve employment-related problems; (3-17-22)

g. Assist the participant to identify and develop community resources to meet specific needs; and (3-17-22)

h. Assist the participant in distributing the SSP to CSWs or vendors as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-25)

05. Termination of Services. If an SB decides to end services with a participant, they must give the participant and the Department at least thirty (30) days' written notice prior to terminating services. The SB must assist the participant to identify a new SB and provide the participant and new SB with a written service transition plan by the date of termination. The transition plan must include an updated SSP that reflects current supports being received, details about the existing CSWs, and unmet needs. (7-1-25)

137. -- 139. (RESERVED)

140. COMMUNITY SUPPORT WORKER (CSW) LIMITATIONS.
A paid CSW must not be the spouse of the participant. For FDCS, they must: 1) not be the parent or legal guardian of the participant, 2) not have direct control over the participant's choices, 3) avoid any conflict of interest, and 4) not receive undue financial benefit from the participant's choices. (7-1-25)

01. Work Limit. A CSW for SDCS cannot work more than twelve (12) hours in a day without authorization from the Department. (7-1-25)

02. SDCS. SDCS CSW cannot be younger than seventeen (17) years of age except when providing chore services and then may be sixteen (16) years of age. (7-1-25)

03. FDCS. A paid CSW may provide unskilled supervision, but cannot: (7-1-25)

a. Supplant the role of the parent or legal guardian; (7-1-25)

b. Be paid to fulfill any obligations that the parent or legal guardian is legally responsible to fulfill for their child.: (7-1-25)

c. Be under the age of sixteen (16) years old; or (7-1-25)

d. Transport or be left alone with a participant under the age of eighteen (18) years old. (7-1-25)

141. -- 149. (RESERVED)

150. PAID COMMUNITY SUPPORT WORKER (CSW) DUTIES AND RESPONSIBILITIES.

01. Initial Documentation. Prior to providing goods or services to the participant, the CSW must type and complete the packet of information provided by the FEA and submit to the FEA. When the CSW will be providing services, this packet must include documentation of: (7-1-25)

a. A completed background check, including clearance in accordance with these rules and IDAPA 16.05.06, "Criminal History and Background Checks," or documentation that this requirement has been waived by the participant in accordance with these rules. Individuals listed on a state or federal provider exclusion list must not provide paid supports; (7-1-25)

b. A completed employment agreement with the participant in accordance with these rules. If the CSW is provided through an agency, the employment agreement must include the specific individual who will provide the support and the agency's responsibility for tax-related obligations; (7-1-25)

c. Current state licensure or certification if identified support requires certification or licensure; and (3-17-22)

d. A statement of qualifications to provide supports identified in the employment agreement. (3-17-22)

02. Employment Agreement. The CSW must deliver supports as defined in the employment

agreement. (7-1-25)

03. Documentation. The CSW must track and document the time required to perform the identified supports and accurately report the time on the time sheets provided by the participant's FEA or complete an invoice that reflects the type of support provided, the date the support was provided, and the negotiated rate for the support provided, for submission to the participant's FEA. Failure to do so may result in recoupment. (7-1-25)

04. Time Sheets and Invoices. The CSW must obtain the signature of the participant or their legal representative on each completed timesheet or invoice prior to submitting the document to the FEA for payment. Time sheets or invoices that are not signed by the CSW and the participant or their legal representative will not be paid. (7-1-25)

151. -- 159. (RESERVED)

160. SUPPORT AND SPENDING PLAN (SSP) DEVELOPMENT.

01. Requirements. The participant, with the help of their SB, must develop a comprehensive SSP based on the information gathered during person-centered planning. The person-centered planning process must meet all HCBS requirements as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." The SSP is not valid until authorized by the Department. The SSP must include: (7-1-25)

a. The participant's preferences and interests by identifying all the supports and services, both paid and non-paid, the participant wants and needs to live successfully in their community. (3-17-22)

b. Paid or non-paid supports that focus on the participant's wants, needs, and goals in the following areas: (7-1-25)

i. Personal health and safety including quality of life preferences; (3-17-22)

ii. Securing and maintaining employment for SDCS; (7-1-25)

iii. Establishing and maintaining relationships with family, friends and others to build the participant's COS; (7-1-25)

iv. Learning and practicing ways to recognize and minimize interfering behaviors for SDCS; and (7-1-25)

v. Learning new or improving existing skills to accomplish set goals for SDCS. (7-1-25)

c. Support needs such as: (3-17-22)

i. Medical care and medicine for SDCS; (7-1-25)

ii. Skilled care including therapies or nursing needs for SDCS; (7-1-25)

iii. Community involvement; (3-17-22)

iv. Preferred living arrangements including possible roommate(s); and (3-17-22)

v. Response to emergencies including access to emergency assistance and care. This plan should reflect the wants, preferences, and needs of the whole person, regardless of payment source, if any. (3-17-22)

d. Risks or safety concerns in relation to the identified support needs on the participant's SSP. The plan must be active and specify the goods, supports or services needed to address the risks for each issue listed, with at least three (3) backup plans for each identified risk to implement in case the need arises; (7-1-25)

e. Sources of payment for the listed supports and services, including the frequency, duration, and

main task of the listed supports and services; (3-17-22)

f. The budgeted amounts planned in relation to the participant's needed supports.The FEA will compare and match the employment agreements to the appropriate support categories identified on the initial SSP prior to processing time sheets or invoices for payment; and (7-1-25)

02. Limitations. (7-1-25)

a. Traditional Adult DD waiver services, rehabilitative, or habilitative services must not be purchased under the CDCS option. Because a participant cannot receive these traditional services and CDCS at the same time, the participant, the SB, and the Department must all work together to ensure that there is no interruption of required services when moving between traditional services and the CDCS option; (7-1-25)

b. Paid community supports must not be provided in a group setting with recipients of traditional Adult DD waiver services, rehabilitative, or habilitative services. This does not prevent a participant who has selected the CDCS option from choosing to live with recipients of traditional Adult DD waiver, rehabilitative, or habilitative services; (7-1-25)

c. All paid community supports must fit into a type of community support described in these rules. The SSP must not include supports or services that are illegal, that adversely affect the health and safety of the participant, that do harm, or that violate or infringe on the rights of others; (7-1-25)

d. SSPs that exceed the approved budget amount will not be authorized; and (7-1-25)

e. Time sheets or invoices exceeding the authorized SSP amount will not be paid by the FEA. (7-1-25)

161. -- 179. (RESERVED)

180. CIRCLE OF SUPPORTS.

01. Focus. The participant's COS is built and operates with the primary goal of working in the interest of the participant. The group's role is to give and get support for the participant and to develop an SSP, along with and on behalf of the participant, to help the participant accomplish their personal goals. (7-1-25)

02. Members. A COS is unpaid, selected by the participant, and may include family members, friends, neighbors, co-workers, and other community members. For the SDCS, when the participant's legal guardian is selected as a CSW, the COS must include at least one (1) non-family member who is not the SB. For the purposes of this chapter a family member is anyone related by blood or marriage to the participant or legal guardian. (7-1-25)

03. Selection and Duties. Members are selected by the participant and commit to work within the group to: (7-1-25)

a. Promote and improve the life of the participant in accordance with the participant's choices and preferences; and (7-1-25)

b. Meet regularly to assist the participant to accomplish their expressed goals. (7-1-25)

04. Natural Supports. Natural supports may perform any duty of the SB as long as the SB still completes the required responsibilities listed in these rules. Additionally, any CSW task may be performed by a qualified natural support person. Supports provided by a natural support person must be identified on the participant's SSP, but time worked does not need to be recorded or reported to the FEA. (7-1-25)

181. -- 189. (RESERVED)

190. INDIVIDUALIZED BUDGET.
The Department will assign budgets based on the criteria under IDAPA 16.03.10, “Medicaid Enhanced Plan

Benefits." (7-1-24)

191. -- 199. (RESERVED)

200. QUALITY ASSURANCE.
The Department will implement quality assurance processes to ensure: access to CDCS, participant direction of SSPs and services, participant choice and direction of providers, safe and effective environments, and participant satisfaction with services and outcomes. (7-1-25)

01. Adult Services Outcome Review (ASOR). Each participant will have the opportunity to provide feedback to the Department about their satisfaction with consumer-directed services utilizing the ASOR. (7-1-25)

02. Adult Service Outcomes. Participant experience information will be gathered at least annually in an interview by the Department, and will address the following participant outcomes: (7-1-25)

a. Access to care; (3-17-22)

b. Choice and control; (3-17-22)

c. Respect and dignity; (3-17-22)

d. Community integration; and (3-17-22)

e. Inclusion. (3-17-22)

03. CSWs and SBs Quality Assurance Activities. CSWs and SBs must participate and comply with quality assurance activities identified by the Department including performance evaluations, satisfaction surveys, quarterly review of services provided by a legal guardian, if applicable, and spot audits of time sheets and billing records. (7-1-25)

04. Participant Choice of Paid CSW. Paid CSWs must be selected by the participant, or their chosen representative, and meet the qualifications identified in this rule. (7-1-25)

05. Complaint Reporting and Tracking Process. The Department will maintain a complaint reporting and tracking process to ensure participants, workers, and other supports have the opportunity to readily report instances of abuse, neglect, exploitation, or other complaints regarding the HCBS program. (3-17-22)

06. Quality Oversight Committee. A Quality Oversight Committee consisting of participants, family members, community providers, and Department designees will review information and data collected from the quality assurance processes to formulate recommendations for program improvement. (3-17-22)

07. Quarterly Quality Assurance Reviews. On a quarterly basis, the Department will perform an enhanced review of services for those participants who have waived the criminal history check requirement for a community support worker or who have their legal guardian providing paid services. These reviews will assess ongoing participant health and safety and compliance with the approved SSP. (7-1-25)

08. HCBS Specific Reviews. The Department will implement quality assurance and improvement activities to ensure compliance with the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-25)

201. -- 209. (RESERVED)

210. CONTINUATION OF THE CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS) OPTION.
The following requirements must be met or the Department may require the participant to discontinue the CDCS option: (3-17-22)

01. Required Supports. The participant is willing to work with an SB. (7-1-25)

a. The participant can only change FEA services by providing a written request to their current FEA provider at least sixty (60) days in advance, and this change must occur at the end of a fiscal quarter. The request must include the name of the new FEA chosen by the participant and provide the specific date the change will occur. (3-17-22)

b. When a participant provides a written request to their current FEA provider to change to a different FEA provider, the current FEA provider must notify the participant of the specific date that the last payroll run will occur at the end of the fiscal quarter. (3-17-22)

02. SSP. The participant's SSP is followed. (7-1-25)

03. Risk and Safety Back-Up Plans. Back-up plans to manage risks and safety are followed. (7-1-25)

04. Health and Safety Choices. The participant's choices do not directly endanger their health, welfare and safety or endanger or harm others. (3-17-22)

211. -- 299. (RESERVED)

FISCAL EMPLOYER AGENTS
(Sections 300-314)

300. FISCAL EMPLOYER AGENT (FEA): DEFINITIONS.
For purposes of Sections 300 through 316, the following definitions apply: (7-1-25)

01. Employee. A CSW employed by a participant receiving services under the CDCS option. (7-1-25)

02. Employer. A participant receiving services under the CDCS option. (3-17-22)

03. Provider. The term “provider” specifically refers to the FEA providing FMS to individuals participating in the CDCS option. (7-1-25)

04. Secure File Transfer Protocol (SFTP). A secure means of transferring data that allows certain Department staff to access information regarding CDCS participants. (7-1-25)

05. Vendor. Agencies and independent contractors that provide goods and services in accordance with a participant’s SSP. (7-1-25)

06. Medicaid Billing Report. A report generated every payroll period by the provider; it provides a list and count of unduplicated participants and payroll expenditures by service code, based on the date of service time frame specified by the user. (3-17-22)

301. FISCAL EMPLOYER AGENT: REQUIREMENTS AND LIMITATIONS.

01. Limitations. The FEA must not: (7-1-25)

a. Provide any other direct services to the participant, to ensure there is no conflict of interest; or (7-1-25)

b. Employ the guardian, parent spouse, payee or conservator of the participant or have direct control over the participant’s choice. (7-1-25)

302. FISCAL EMPLOYER AGENT: DUTIES AND RESPONSIBILITIES.
The FEA performs FMS for each participant. Prior to providing FMS the participant and the FEA must enter into a written agreement. FMS include: (7-1-25)

01. Payroll and Accounting. Providing supports to participants that have chosen the CDCS option

including: (7-1-25)

a. An online electronic time sheet entry for participants; (7-1-25)

b. Processing time sheets for CSWs and SBs, as authorized by the participant, according to the participant's Department-authorized SSP; and (7-1-25)

c. Issuing payroll checks after receipt of completed, approved time sheets. (7-1-25)

02. Recoupment. Recoup payments made in error when identified by the FEA or the Department by either deducting from future payments or requiring repayment. (7-1-25)

03. Financial Reporting. Performing financial reporting for employees of each participant. (7-1-25)

04. Information Packet. Preparing and distributing a packet of information, including Department-approved forms for agreement, for the participant hiring their own staff. (7-1-25)

05. Labor Laws. Ensure each participant's compliance with all applicable labor laws. (7-1-25)

06. Taxes. Ensure each participant's compliance with regulations for both federal and state taxes, including preparation and submission of all federal and state forms for each participant and their employees. Manage and process payment of required state and federal employment taxes for the participant's CSWs and SB. (7-1-25)

07. Payments of Goods and Services. Process and pay invoices for goods and services, as authorized by the participant, according to the participant's SSP. (7-1-25)

08. Spending Information. Providing each participant with reporting information that will assist the participant with managing the individualized budget. (7-1-25)

09. Quality Assurance and Improvement. Participating in Department quality assurance activities. (7-1-25)

303. FISCAL EMPLOYER AGENT (FEA): CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS).

01. Federal Tax ID Requirement. The FEA must obtain a separate Federal Employer Identification Number (FEIN) specifically to file tax forms and to make tax payments on behalf of program participants. In addition, the provider must: (7-1-25)

a. Maintain copies of the participant's FEIN, IRS FEIN notification letter, and Form SS-4 Request for FEIN in the participant's file. (3-17-22)

b. Retire participant's FEIN when the participant is no longer an employer under CDCS. (7-1-25)

02. Requirement to Report Irregular Activities or Practices. The provider must report to the Department any facts regarding irregular activities or practices that may conflict with federal or state rules and regulations; (3-17-22)

03. Policies and Procedures. The provider must maintain a current manual containing comprehensive policies and procedures. The provider must submit the manual and any updates to the Department for approval. (3-17-22)

04. Key Contact Person. The provider must provide a key contact person and at least (2) two other people for backup who are responsible for answering calls and responding to e-mails from Department staff and respond to the Department within one (1) business day. (7-1-25)

05. Face-to-Face Transitional Participant Enrollment. The provider must conduct face-to-face

transitional participant enrollment sessions in group settings or with individual participants in their homes or other designated locations. The provider must work with the regional Department staff to coordinate and conduct enrollment sessions. The face-to-face encounter may occur via virtual care, as defined in Title 54, Chapter 57, Idaho Code. (7-1-25)

06. SFTP Site. The provider must provide an SFTP site for the Department to access with the capability of allowing participants and their employees to access individual specific information such as time cards and account statements. The site must be user name and password protected. The provider must have the site accessible to the Department upon commencement of the readiness review. (7-1-25)

07. Required IRS Forms. The provider must prepare, submit, and revoke the following IRS forms in accordance with IRS requirements and must maintain relevant documentation in each participant's file including: (3-17-22)

a. IRS Form 2678; (3-17-22)

b. IRS Approval Letter; (3-17-22)

c. IRS Form 2678 revocation process; (3-17-22)

d. Initial IRS Form 2848; and (3-17-22)

e. Renewal IRS Form 2848. (3-17-22)

08. Requirement to Obtain and Revoke Power of Attorney. The provider must obtain an Idaho State Tax Commission Power of Attorney (ID-POA) from each participant it represents, revoke the Form ID-POA when the provider no longer represents the participant, and maintain the relevant documentation in each participant's file. (3-17-22)

304. FISCAL EMPLOYER AGENT (FEA): CUSTOMER SERVICE.

01. Customer Service System. The provider must provide a customer service system to respond to all inquiries from participants, employees, agencies, and vendors. The provider must: (3-17-22)

a. Provide staff with customer service training with an emphasis on consumer-direction. (3-17-22)

b. Ensure staff are trained and have the skills to assist participants with enrollment and to help them understand their account statements. (3-17-22)

c. Ensure that FEA personnel are available during regular business hours. (7-1-25)

d. Provide translation and interpreter services. (7-1-25)

e. Provide prompt and consistent response to verbal and written communication. Specifically: (3-17-22)

i. All calls and voice mails must be responded to within one (1) business day; and (7-1-24)

ii. All written and electronic correspondence must be responded to within five (5) business days. (3-17-22)

f. Maintain a toll-free phone line where callers speak to a live person during business hours and are provided the option to leave voice mail at any time. (7-1-25)

g. Maintain a toll-free fax line that is available at any time, exclusively for participants and their employees. (7-1-25)

h. Maintain an e-mail address. (7-1-25)

02. Complaint Resolution and Tracking System. The provider is responsible for receiving, responding to, and tracking all complaints from any source under this agreement and corrective actions. A complaint is defined as a verbal or written expression of dissatisfaction about FEA services. The provider must: (7-1-25)

a. Respond to all written and electronic correspondence within five business (5) days. (7-1-24)

b. Respond to all calls and voicemails within one (1) business day. (7-1-24)

c. Maintain an electronic tracking system and log of complaints and resolutions accessible for Department review through the SFTP site. (7-1-25)

d. Log and track complaints received from the Department pertaining to FEA services. (7-1-25)

e. Compile a quarterly summary report analyzing complaints to determine the quality of services to participants and to identify any corrective action necessary. (7-1-25)

f. Implement corrective action within one (1) business day of the complaint response. (7-1-25)

g. Post the complaint to the SFTP site within one (1) business day. Failure to comply will result in a fifty dollar ($50) penalty payable to Medicaid within ninety (90) days of incident. (7-1-25)

305. FISCAL EMPLOYER AGENT (FEA): PERSONAL AND CONFIDENTIAL INFORMATION.
The provider must implement and enforce policies and procedures regarding documents that are mailed, faxed, or e-mailed to and from the provider to ensure documents are tracked and that confidential information is not compromised, is stored appropriately and not lost, and is traceable for historical research purposes. (7-1-25)

306. FISCAL EMPLOYER AGENT (FEA): ENROLLMENT PROCESS.

01. Submission of Participant Enrollment and Employee Packets for Department Approval. The provider must submit the following for participant enrollment and employee packets to the Department for approval. (3-17-22)

a. The participant enrollment packet must include: (3-17-22)

i. FEA authorization form; (7-1-25)

ii. Employer Appointment of Agent - IRS Form; (3-17-22)

iii. Tax Information Form; and (3-17-22)

iv. Employer information including; (7-1-25)

(1) Instructions for completing forms; (3-17-22)

(2) Payroll schedule, including deadlines for submission of time cards; (3-17-22)

(3) Sample employment agreements; (3-17-22)

(4) Sample Request for Vendor Payment form; (3-17-22)

(5) Sample independent provider agreement; and (3-17-22)

(6) Other sample employment agreements as needed. (3-17-22)

b. The employee enrollment packet must contain: (3-17-22)

i. Employee Information Form; (3-17-22)

ii. I-9 Employment Eligibility Form; (3-17-22)

iii. W-4 Employee Withholding Allowance Certificate; (3-17-22)

iv. Pay selection agreement; (3-17-22)

v. Direct deposit authorization (optional); and (7-1-25)

vi. Sample time sheets and instructions for completion. (7-1-25)

02. Distribution of Participant Enrollment and Employee Packets to Participant after Department Approval. The provider must distribute Department-approved participant enrollment packets and employment packets to the participant within two (2) business days after the participant requests the packets. (3-17-22)

a. To enroll a participant, the provider must: (3-17-22)

i. Enroll the participant within two (2) business days of receipt of completed paperwork; and (3-17-22)

ii. Log and maintain an electronic record of all enrollment paperwork, which includes participant SSP cost and authorization sheets. (7-1-25)

b. To enroll an employee, the provider must: (3-17-22)

i. Enroll the employee within two (2) business days of receipt of completed paperwork; and (3-17-22)

ii. Log and maintain an electronic record of all the employee's paperwork that includes the employment agreements. (3-17-22)

307. FISCAL EMPLOYER AGENT (FEA): PAYMENT PROCESS.

01. Process Payroll. The provider must process payroll, including time sheets and taxes, in accordance with the participant's SSP. The payroll process must include: (7-1-25)

a. Payment of employer and withholding taxes to State Tax Commission and Internal Revenue Service. (3-17-22)

b. Payment of invoices to vendors. (3-17-22)

c. Management of participant budget funds as per authorized SSP. (7-1-25)

d. Garnishment of wages as per court orders. (3-17-22)

e. Preparation of year-end federal and state tax forms. (3-17-22)

f. Payment of worker's compensation insurance premiums. (3-17-22)

02. Requirement to Track and Log Time Sheet Billing Errors. The provider must track and log time sheet billing errors or time sheets that cannot be paid due to late arrival, missing, or erroneous information. The provider must notify the employee and participant within one (1) business day of when errors are identified on the time sheets. (3-17-22)

03. Requirement to Track and Log Improperly Cashed or Improperly Issued Checks. The provider must track and log occurrences of improperly cashed or improperly issued checks and stop payment on checks when necessary. The provider must reissue lost, stolen, or improperly issued checks at no expense to the participant or the Department within fourteen (14) calendar days of when the error occurred. (3-17-22)

04. Process Employee Payments. The provider must verify documentation and process payments via the preference of employees. The employee payment process includes: (7-1-25)

a. Receipt of time cards from employees via mail, fax, or website by specified due dates. (3-17-22)

b. Review time cards for accuracy and verify that timecards contain the following information: (3-17-22)

i. Employer name and ID number. (3-17-22)

ii. Employee name and ID number. (3-17-22)

iii. Hours of work. (3-17-22)

iv. Code for service. (3-17-22)

c. Match codes to employment agreement to verify rate of pay. (3-17-22)

d. Verify that rate of pay multiplied by the hours worked per each pay period is equal to the gross pay. (3-17-22)

e. Calculate all taxes and other withholding. (3-17-22)

f. Pay employees every two (2) weeks or semi-monthly. (3-17-22)

g. Contact participant and representative to resolve problems with timecards or other documents prior to pay-date, if possible. (7-1-25)

h. Maintain an electronic complaint log of payroll issues and resolutions. (3-17-22)

i. Verification of any money remaining in each participant's budget and specific service category prior to issuing payment. (7-1-25)

05. Process Vendor Payments. When participants submit requests for payment to vendors, the provider must: (3-17-22)

a. Review, and maintain on file, the vendor payment request with attached voided vendor receipt submitted by the participant. (3-17-22)

b. Ensure item or payment is authorized on the participant's SSP. (7-1-25)

c. Issue payment to the vendor on the same schedule as payroll. (7-1-25)

06. Process Independent Contractor or Outside Agency Payments. When the participant hires an independent contractor or outside agency, in accordance with the SSP, the provider must: (7-1-25)

a. Obtain a W-9 from the contractor or agency. (3-17-22)

b. Review, and maintain on file, the independent contractor or agency agreement submitted by the participant. (3-17-22)

c. Review, and maintain on file, the independent contractor or agency invoice for services submitted

by the participant. (3-17-22)

d. Ensure service or payment is authorized on the SSP. (7-1-25)

e. Issue payment directly to the independent contractor or agency. (3-17-22)

07. End-of-Year Processing. For purposes of end-of-year processing, the provider must maintain relevant documentation and must: (3-17-22)

a. Refund over-collected Federal Insurance Contributions Act tax (FICA) to applicable employees, or to state government; (3-17-22)

b. Prepare, file, and distribute IRS Form W-2 for each employee; (3-17-22)

c. Prepare and file IRS Form W-3 for each participant represented; (3-17-22)

d. Prepare and file State Form 967 for state income taxes withheld for each employer; (7-1-25)

e. Report and pay any Unclaimed Property per Idaho State Tax Commission rules; and (3-17-22)

f. Report and pay all state and federal unemployment insurance premiums. (3-17-22)

08. Transition to New FEA. The following items must be addressed if a participant transitions to a new FEA provider. For the purposes of a smooth transition between FEA providers, the two providers must work closely with one another to transfer the participant from the services one is no longer providing to the services the other is providing. The following items must be transferred: (3-17-22)

a. Participant's FEIN and FEIN mailing address. (7-1-25)

b. IRS Form 2678 Agent/Payer Authorization. (3-17-22)

c. Depositing taxes and filing report. This includes Federal and State tax withholdings and Federal Unemployment Tax Act tax (FUTA). (3-17-22)

d. Participant's FUTA Liability Status. (3-17-22)

e. FICA and FUTA Exemption Status of Participant Employees. (7-1-25)

f. Unemployment Insurance (U/I). (3-17-22)

g. Unemployment Insurance Experience Rate and Taxable Wage Base. (3-17-22)

h. State Unemployment Insurance Liability Status of the Participant and Exempt Employees. (7-1-25)

i. Unemployment Insurance Filing and Depositing. (3-17-22)

j. State Income Tax - Account Number Agent Authorization, Filing and Depositing. (7-1-25)

k. Budget Authorization - Authorized Services Spent and Remaining, Authorized Providers, and Authorized Provider Rates. (7-1-25)

l. Participant's Representative, and Participant's Employee and Provider Demographic Information. (7-1-25)

m. Participant's Employee New Hire Reporting, Liens and Garnishments, and Tax and Other Information. (7-1-25)

n. Participant's Independent contract and other information. (3-17-22)

308. FISCAL EMPLOYER AGENT (FEA): ANNUAL PARTICIPANT SURVEY.

01. Requirement to Conduct Annual Participant Satisfaction Survey. Starting October 1 of each calendar year, each provider who has been providing services for at least six (6) months must conduct an annual participant satisfaction survey. (3-17-22)

a. Three (3) weeks prior to the survey launch, the provider must present the questions to the Department staff for approval. (3-17-22)

b. Once the questions are approved by the Department, the provider can send out the survey. (3-17-22)

c. The provider must survey its participants who receive services under the CDCS option, including those whose primary language is other than English. (7-1-25)

d. The provider must provide options for participants to respond to the surveys, other than by mail. (7-1-25)

02. Requirement to Provide Results of Annual Participant Satisfaction Survey. The provider must provide the results of the surveys to the Department in a comprehensive report, along with the completed surveys, by the 15th of December each calendar year. (7-1-25)

309. FISCAL EMPLOYER AGENT (FEA): QUALITY ASSURANCE.

01. Quality Assurance Activities. The FEA must participate in quality assurance activities identified by the Department such as readiness reviews, periodic audits, maintaining a list of background check waivers, and timely reporting of accounting and satisfaction data. (7-1-25)

02. Elements of Quality Assurance Process. The provider must provide a quality assurance process that includes: (7-1-25)

a. Implementation of a quality management plan; (3-17-22)

b. Preparation of a quarterly, quality management analysis report; (3-17-22)

c. Distribution, collection, and analysis of an annual participant satisfaction survey; and (3-17-22)

d. A review of the monthly complaint summary and resolutions, monitoring of standards, and implementation of program improvements as needed. (3-17-22)

03. Formal Quality Assurance Review. Every two (2) years, the provider must participate in a formal quality assurance review conducted in collaboration with the Department. (7-1-25)

310. FISCAL EMPLOYER AGENT (FEA): DISASTER RECOVERY PLAN.

01. Disaster Recovery Plan. The provider must develop and maintain a Disaster Recovery Plan for electronic and hard copy files that includes restoring software and data files, and hardware backup if management information systems are disabled or servers are inoperative. The results of the Disaster Recovery Plan must ensure the continuation of payroll and invoice payment systems. The provider must submit the Disaster Recovery Plan for Department approval during the readiness review. (3-17-22)

02. Requirement to Report a Disaster. The provider must report to the Department if management information systems are disabled or servers are inoperative within twenty-four (24) hours of the event. (3-17-22)

311. FISCAL EMPLOYER AGENT (FEA): TRANSITION PLAN.

01. Transition Plan Objectives. The provider must provide a transition plan to the Department for the readiness review. The objectives of the transition plan are to minimize the disruption of services and provide an orderly and controlled transition of the provider's responsibilities to a successor at the conclusion of the agreement period or for any other reason the provider cannot complete responsibilities described in this chapter of rules. (7-1-25)

02. Transition Plan Requirements. The transition plan must: (3-17-22)

a. Be updated at least ninety (90) days prior to termination of the provider agreement. (3-17-22)

b. Include tasks, and subtasks for transition, a schedule for transition, operational resource requirements, and training to be provided. (3-17-22)

c. Provide for transfer of data, documentation, files, and other records relevant to the agreement in an electronic format accepted by the Department. (3-17-22)

d. Provide for the transfer of any current, Idaho-specific policy and procedure manuals, brochures, pamphlets, and all other written materials developed in support of agreement activity to the Department. (3-17-22)

312. FISCAL EMPLOYER AGENT (FEA): PERFORMANCE METRICS.

01. Readiness Review. Complete a readiness review conducted by the Department with the provider prior to providing FEA services. (7-1-25)

a. The Department will access SFTP site for review of provider documents and conduct an onsite review. (7-1-24)

02. Fiscal Support and Financial Consultation. (3-17-22)

a. The provider must provide each participant with fiscal support and financial consultation. (3-17-22)

03. Quarterly Reconciliation. Each fiscal quarter after initiating service, the provider must reconcile its Medicaid Billing Report to a zero-dollar ($0) balance with the Medicaid Bureau of Financial Operations. The provider has ninety (90) days to comply with reconciling each participant's SSP balance to a zero dollar ($0) balance with Medicaid's reimbursements. The provider must: (7-1-25)

a. Show one hundred percent (100%) compliance with the required quarterly reconciliation of the Medicaid Billing Report. (7-1-25)

b. Notify the Department immediately if an issue is identified that may result in the provider not reconciling the Medicaid Billing Report. The Department will notify the provider when a performance issue is identified. The Department may require the provider to submit a written corrective action plan for Department approval within two (2) business days after notification. If the provider fails to reconcile within ninety (90) days after the end of each quarter, the provider will be penalized fifty dollars ($50) each week until the provider has reconciled with Medicaid to a zero dollar ($0) balance. (7-1-24)

04. Cash Management Plan. Each provider's cash management plan must equal one point five (1.5) times the monthly payroll cycle amount and can be forms of liquid cash and lines of credit. For example, if a provider's current payroll minimum has averaged one hundred thousand dollars ($100,000) per payroll cycle, the provider would be required to have one hundred fifty thousand dollars ($150,000) in a cash management plan. The Department must be on the notification list if any lines of credit are decreased in the amount accessible or terminated. The expectation is to provide a seamless payroll cycle to the participant, without loss of pay to their employees. (7-1-24)

313. FISCAL EMPLOYER AGENT (FEA): REPORTS.

01. Account Summary Statements. This report provides an overview of each participant account and includes the services accessed and the remaining dollar amount in the budget as well as information on how to read the report. In addition to providing this monthly report, a participant may request this report for a specified timeframe. Each month, the provider must at the participant's preference mail a hard copy of the report to each participant or make the report available on a secure website. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. This SFTP site must have a user name and password protection. (7-1-25)

a. Report Format: Microsoft Excel. (7-1-25)

b. Report Due Date: The 10th day of each month. (7-1-25)

02. Medicaid Billing Report. This report provides a detailed breakdown of CSW services rendered by service date per employee, per employer. Each line on this report must provide the following information: employee name and ID number, hours worked, period start, and period end, pay rate, service date, check number and date, participant's name, participant's date of birth, participant's ID number, service code, taxes, and billing amount. This report collects information based on the timeframe specified by the user. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. (7-1-25)

a. Report Format: Microsoft Excel. (7-1-25)

b. The 10th day of each month. (7-1-25)

03. Demographic Report. This report provides general client demographics in the region and the employee count per participant for each participant in the database. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. (7-1-25)

a. Report Format: Microsoft Excel. (7-1-25)

b. Report Due Date: The 10th day of each month. (7-1-25)

04. Background Check Report. This report provides a breakdown, by participant, of which employees the participant waived the background check, which employees passed or failed the background check, the background check reference number, and the date the background check was submitted. This report does not include SBs. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. (7-1-25)

a. Report Format: Microsoft Word, Microsoft Excel, or PDF. (7-1-25)

b. Report Due Date: The 10th day of each month. (7-1-25)

05. Medicaid Billing Report. This report provides a list and count of the unduplicated participants and expenditures by services code based on the time frame specified by the user. The provider must generate the report after every payroll and post it on a SFTP site. Additionally, the provider must provide a quarterly Medicaid Billing Report that can been reconciled quarterly and work with the Department to reconcile the annual report. (3-17-22)

a. Report Format: Microsoft Excel. (7-1-25)

b. Report Due Date: The 10th day of each month. (7-1-25)

06. Complaint and Resolution Summary Report. The provider must analyze complaints received on a quarterly basis to determine the quality of services to participants and identify any corrective actions and program improvements needed and implemented. The provider must post the report on a secure SFTP site for Department review. (3-17-22)

a. Report Format: Microsoft Word, Microsoft Excel, or PDF. (7-1-25)

b. Report Due Date: The 10th day of the month following the end of each annual quarter. (7-1-25)

07. Customer Satisfaction Survey Report. The provider must provide a comprehensive report summarizing the results of the customer satisfaction survey completed by each participant. (3-17-22)

a. Report Format: Microsoft Word, Microsoft Excel, or PDF. (7-1-25)

b. Report Due Date: December 1st of each year. (7-1-25)

08. Quarterly Financial Statements. The provider must provide the Department a quarterly balance sheet and income statement that shows the provider's quarterly financial status and cash management plan cash reserve. (3-17-22)

a. Report Format: Microsoft Word, Microsoft Excel, or PDF. (7-1-25)

b. Report Due Date: The 25th day of the month following the end of each annual quarter. (7-1-25)

314. FISCAL EMPLOYER AGENT (FEA): PAYMENT REQUIREMENTS.

01. Per Member Per Month (PMPM) Payment. The Department will pay, and the provider must accept a PMPM payment that covers a comprehensive set of FEA services. The Department will set allowable reimbursement rates for PMPM based on a methodology approved by CMS in the Adult DD Waiver. The provider can only bill the PMPM rate for the months services are actually provided for participants, The provider must provide transition, training, and closeout services during the active agreement, at no additional cost to the Department. (7-1-25)

02. PMPM Payment Process Requirements. The PMPM payment must include all administrative costs, travel, transition, training, and closeout services. The Department will not pay for participants who do not have an SSP. For the purposes of PMPM payment, one (1) month must include all payroll batch dates within that specific calendar month. (7-1-25)

03. Readiness Review. The provider must complete a readiness review prior to billing for services. (7-1-25)

315. TERMINATION OF FISCAL EMPLOYER AGENT (FEA) PROVIDER AGREEMENTS.

In the event of termination of a provider agreement, the provider must: (7-1-25)

01. Continuation of Services. Ensure continuation of services to participants for the period in which a PMPM payment has been made, and submit the information, reports and records, including the Medicaid Billing Report as specified in these rules. (7-1-25)

02. Advanced Notice. Provide to the Department a written notice ninety (90) days in advance and the change notification must occur at the end of the next calendar quarter. (7-1-25)

03. Termination of Service. Provide to the participant a written notice ninety (90) days in advance. The change notification must occur at the end of the next calendar quarter. (7-1-25)

316. REMEDIES TO NONPERFORMANCE OF A FISCAL EMPLOYER AGENT (FEA) SERVICE PROVIDER.

01. Remedial Action. If any of the services do not comply with the performance metrics under these rules, the Department will consult with the provider and may, at its sole discretion, require any of the following remedial actions, taking into account the scope and severity of the noncompliance, compliance history, the integrity of the program, and the potential risk to participants. (7-1-25)

a. Require the provider to take corrective action to ensure that performance meets the performance metrics under Section 310 of these rules; (3-17-22)

b. Reduce payment to reflect the reduced value of services received; (3-17-22)

c. Require the provider to subcontract all or part of the service at no additional cost to the Department; or (3-17-22)

d. Terminate the provider agreement with notice. (3-17-22)

02. Direct Monetary Action. If any of the performance metrics under Section 310 of these rules are not met, the Department will enforce a fifty dollar ($50) a week penalty for each performance metric not met. The penalty will be captured prior to any payment from the Department to the provider. (3-17-22)

317. -- 999. (RESERVED)