Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Idaho** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Aged and Disabled Waiver

C. Waiver Number:ID.1076
Original Base Waiver Number: ID.1076.90.R3A.04

D. Amendment Number: ID.1076.R05. ~~02~~03

E. Proposed Effective Date: *(mm/dd/yy)*
~~07/01/16~~01/01/17
Approved Effective Date:
Approved Effective Date of Waiver being Amended: 10/01/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

Character Count: 556 out of 12000

The purposes of this amendment to Idaho's Aged and Disabled (A&D) Waiver are as follows:

1) To reflect a change in the reimbursement methodology for Residential Habilitation - Supported Living.

2) To reflect a change in the geographic service area of the Medicare-Medicaid Coordinated Plan (MMCP). The Managed Care Entity (MCE) that currently administers the MMCP received approval from the Centers for Medicare and Medicaid Services (CMS) to reduce the service area of this Fully Integrated Dual Eligible Special Needs Plan to 22 of Idaho's 42 counties.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (check each that applies):

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	Main, 6. Attachment 1, Attachment 2
☐ **Appendix A Waiver Administration and Operation**	
☐ **Appendix B Participant Access and Eligibility**	
☐ **Appendix C Participant Services**	
☐ **Appendix D Participant Centered Service Planning and Delivery**	
☐ **Appendix E Participant Direction of Services**	
☐ **Appendix F Participant Rights**	
☐ **Appendix G Participant Safeguards**	
☐ **Appendix H**	
☒ **Appendix I Financial Accountability**	2-a, 3-g.iii.
☒ **Appendix J Cost-Neutrality Demonstration**	2-d.

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (check each that applies):

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☒ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☒ **Other**

Specify:

Character Count: 78 out of 6000

Change the geographic service area for the Medicare-Medicaid Coordinated Plan and to reflect updates to financial accountability provisions regarding methods and standards for setting payment rates.

[Sections Omitted]

6. Additional Requirements

I. Public Input. Describe how the State secures public input into the development of the waiver:

Character Count: 5402 out of 6000

Public input is a key element in the development and operation of the A&D waiver. The Department has solicited public input regarding this amendment in a variety of ways:

For this waiver amendment (and corresponding waiver amendment to the Developmental Disabilities waiver), the Department solicited meaningful public input through the following processes:

1. The Department contracted with the accounting firm Myers and Stauffer LC (Myers and Stauffer) to perform a cost survey of residential habilitation providers. This cost survey was conducted in accordance with Idaho Administrative Code 16.03.10.037.01 and 16.03.10.037.04. The cost survey was made available to providers on February 29, 2016. Meyers and Stauffer (i) hosted a webinar on March 14, 2016 to inform providers how to complete the survey, (ii) hosted a second webinar on March 21, 2016 to address follow-up questions from providers, and (iii) were available via phone and email to respond to providers' questions regarding the cost survey. Providers were asked to complete and return the cost survey to Myers and Stauffer on or before April 30, 2016. The final results of the cost survey can be found at http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/SupportedLivingReport.pdf

2. The Department sent written notice and request for comment regarding residential habilitation service reimbursement changes to designated tribal representatives of the six federally recognized tribes located in Idaho on August 12, 2016.

3. Department leadership and a subgroup of the Idaho Association of Community Providers met on August 26, 2016, September 6, 2016 and September 22, 2016 to discuss the preliminary results of the cost survey and gather feedback from the group regarding residential habilitation service reimbursement changes.

4. The Department sent written notification and request for comment regarding residential habilitation service reimbursement changes as follows:

a. To residential habilitation service providers on October 17, 2016.

b. To waiver participants (and/or their decision making authority) receiving residential habilitation services on October 18, 2016 and the Department attempted to follow-up with these individuals via phone to gather comments and address participants' concerns regarding access to care.

c. To targeted service coordinators and support brokers on October 18, 2016.

5. The Department established a dedicated phone line and email address for the public's inquiries related to the residential habilitation reimbursement changes.

6. The Department held a public hearing on October 24, 2016 to discuss the preliminary results of the cost survey and gather feedback from providers, participants and other interested stakeholders regarding residential habilitation service reimbursement changes.

7. The Department published public notice of the waiver amendment in multiple newspapers throughout the State and on the Department's website at www.healthand welfare.idaho.gov. Copies of public notices are made available for public review during regular business hours at any regional or field office of the Idaho Department of Health and Welfare and any regional or local public health district office. In Adams, Boise and Camas counties, copies of the amendments will be available at the county clerk's office in each of these counties. The public was given the opportunity to comment on the proposed reimbursement changes for a period of at least 30 days prior to the submission of this waiver amendment to the Centers for Medicare and Medicaid Services (CMS).

MMCP Service Area Reduction:
1. The Personal Assistance Oversight Committee (PAO) is a subcommittee of the Medical Care Advisory Committee (MCAC). The purpose of the PAO is to plan, monitor, and recommend changes to the Medicaid waiver and personal assistance programs. Such recommendations would be submitted to the MCAC. The PAO consists of providers of personal assistance services and participants of such services, advocacy organizations representing such participants, and other interested parties. This committee meets quarterly and is open to the public. The PAO discussed the service area reduction during the 9/21/2016 meeting.

2. A tribal solicitation was mailed to the Tribal Representatives on 10/31/2016. In addition, ongoing feedback is solicited from Tribal representatives during the quarterly Tribal Meetings.

3. Existing enrollees in the affected counties were mailed notices advising them of the change on 09/06/2016 and 09/30/2016. Network providers in the affected counties were mailed notices on 09/01/2016. A notice of the change was published on the IDHW MMCP webpage, located at http://healthandwelfare.idaho.gov/Medical/Medicaid/MedicaidParticipants/MedicareMedicaidCoordinatedPlan/tabid/2538/Default.aspx . Notification of the upcoming change was also published in the October edition of the MedicAide Newsletter, a publication distributed to Idaho Medicaid providers (https://www.idmedicaid.com/MedicAide%20Newsletters/October%202016%20MedicAide.pdf) All notices included a contact number for stakeholders to call with inquiries.

4. The Health Plan has worked with local Area Agencies on Aging and Senior Health Insurance Benefits Assistance (SHIBA) to facilitate communication and education for enrollees and potential enrollees.

[Sections Omitted]

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☒ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Character Count: 1033 out of 12000

There are currently approximately 200 A&D waiver participants enrolled in the MMCP in the counties that will no longer be in the MMCP service area effective January 1, 2017. Every affected enrollee was mailed a notice explaining the upcoming change on September 6, 2016. For all mail items that were returned as undeliverable, Care Coordinators researched each case to ensure that every member was aware of the change.

Effective January 1, 2017, individuals enrolled in the MMCP in the ineligible counties will revert automatically to fee-for-service (FFS) Medicaid. They have been advised that they have the opportunity to select another Medicare Advantage product or revert to fee-for-service Medicare.

Service transitions for these individuals will be seamless. The process will follow the existing disenrollment process, whereby the individual's selection of service providers and authorizations are transferred to Idaho Medicaid via existing processes. Participants will retain the same waiver service providers and level of service.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Character Count: 52340 out of 60000

In its Statewide Transition Plan (STP), the Idaho Department of Health and Welfare Division of Medicaid (Department) has established processes necessary to bring this waiver into compliance with federal home and community-based settings requirements. The Department's STP received initial approval from the Centers for Medicare and Medicaid Services (CMS) on September 23, 2016.

Idaho assures that the setting transition plan included with this waiver will be subject to any provisions or requirements in the State's approved Statewide Transition Plan. The State will implement any applicable required changes upon approval of the Statewide Transition Plan and will make conforming changes to this waiver, as needed, when it submits the next amendment or renewal. The most recent version of the Statewide Transition Plan can be found here: http://healthandwelfare.idaho.gov/Medical/Medicaid/HomeandCommunityBasedSettingsFinalRule/tabid/2710/Default.aspx

Overview

The intention of the home and community-based services (HCBS) rule is to ensure individuals receiving long-term services and supports through these waiver programs have full access to the benefits of community living and the opportunity to receive services in the most integrated settings appropriate. In addition, the new regulations aim to enhance the quality of HCBS and provide protections to participants.
Idaho Medicaid initiated a variety of activities beginning in July of 2014 designed to engage stakeholders in the development of this Transition Plan. The engagement process began with a series of web-based seminars that were hosted in July through September 2014 and which summarized the new regulations and solicited initial feedback from a wide variety of stakeholders. HCBS providers, participants, and advocates were invited to attend these seminars. The state also launched an HCBS webpage, www.HCBS.dhw.idaho.gov hosting information about the new regulations, FAQs, and updates regarding the development of Idaho's draft Transition Plan. The webpage contains an "Ask the Program" feature whereby interested parties are encouraged to submit comments, questions, and concerns to the project team at any time. Additional opportunities were established to share information and for stakeholders to provide input regarding the new regulations and Idaho's plans for transitioning into full compliance. They are described in more detail throughout this document.

The Transition Plan includes:
- A description of the work completed to date to engage stakeholders in this process

- A systemic assessment of existing support for the new HCBS regulations
- A plan for systemic remediation
- A plan for assessment of all residential and non-residential service settings
- A plan for provider remediation
- A plan for relocation of impacted participants
- A plan for on-going monitoring of all HCBS service settings
- A timeline for remaining activities to bring Idaho into full compliance
- A summary of public comments
- An index of changes made in version three of the Transition Plan

The state received comments from CMS on the Statewide Transition Plan in 2015 and again in early 2016. The state has since developed responses to the comments and also incorporated changes into the Transition Plan to address concerns identified. The CMS letters, along with the state's responses, have been posted on the state's webpage, www.HCBS.dhw.idaho.gov. They can be found under the Resources tab on the right hand side of the home page.

Additional changes to the body of this Transition Plan (v3) were made prior to it being posted on September 11, 2015 and again on June 3, 2016. These changes incorporate updated information; include new details; and, in some instances, add clarifying information. All changes are noted in the Index of Changes (Attachment 7).

Section 1: Systemic Assessment and Systemic Remediation

Idaho completed a preliminary gap analysis of its residential HCBS settings in late summer of 2014 and a preliminary gap analysis of its non-residential HCBS settings in December 2014. The gap analysis included an in-depth review of state administrative rule and statute, Medicaid waiver and state plan language, licensing and certification requirements, Medicaid provider agreements, service definitions, administrative and operational processes, provider qualifications and training, quality assurance and monitoring activities, reimbursement methodologies, and person-centered planning processes and documentation. Please refer to the links provided in the Transition Plan Introduction for access to rule and waiver language. This analysis identified areas where the new regulations are supported in Idaho as well as areas that will need to be strengthened in order to align Idaho's HCBS programs with the regulations.
Please note two things about the systemic assessment of existing support:

1. Idaho looked for existing support for each HCBS requirement to begin the gap analysis. If any support was found, that information was documented in the support row in the gap analysis tables. However, a reference to identified support DOES NOT necessarily mean the requirement is fully supported by the rule(s) cited. In some instances the rule support that was cited only partially supported the requirement and thus additional rule changes are noted in the remediation strategy. For example, IDAPA currently requires residential providers to offer residents three meals a day. The state considers this to be support for the requirement that individuals have access to food at any time, but only partial support. A number of the citations in the "support" column are from Licensing and Certification rules – Medicaid rules set a higher standard for those licensed and certified providers that serve Medicaid participants. Thus, the state identified that additional changes to IDAPA were needed.

2. Idaho acknowledges that this gap analysis is only the first step in the assessment process. It has been used to identify where Idaho lacks documented support for the setting quality requirements. Idaho understands that more work is necessary to complete a full assessment of settings. Section Three of this document identifies the work remaining to complete a thorough assessment. That process includes soliciting input from individuals who live in and use these settings, provider self- assessment, as well as on-site assessment of compliance.

The results of the gap analysis of residential settings were shared with stakeholders via a WebEx meeting on September 16, 2014. The results of the gap analysis of non-residential settings were shared with stakeholders via a WebEx meeting on January 14, 2015. The WebEx presentations and audio recordings were then posted on the Idaho HCBS webpage. This preliminary analysis has informed the recommendation to develop several changes to rule, operational processes, quality assurance activities, and program documentation.

Below is list of services offered under this waiver. Settings that are listed as "in-home" are presumed to meet HCBS compliance, as these are furnished in a participant's private residence. Settings indicated as "community" are also

presumed to meet the HCBS qualities, as they are furnished in the community in which the participant resides. Quality reviews of services and participant service outcome reviews will ensure that providers do not impose restrictions on HCBS setting qualities in a participant's own home or in the community without a supportive strategy that has been agreed to through the person-centered planning process.

Service settings for the A&D Waiver include: Adult Day Health centers, Developmental Disability Agencies, Residential Assisted Living Facilities, Certified Family Homes, private homes, or the community. The tables detailing Idaho's waiver services and the service settings in which those services may occur are located at:

http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=10

1a. Systemic Assessment of Residential Settings

The A&D waiver offers HCBS services in two types of provider owned or controlled residential settings: RALFs and CFHs. The results of Idaho's analysis of these residential settings are summarized below, including an overview of existing support for each regulation. The state has included, where applicable, the full IDAPA citations to identify where IDAPA supports the HCBS requirement, in addition to indicating if IDAPA is silent. The state did not identify any IDAPA provision that conflicts with the HCBS requirements. Additionally, the chart includes preliminary recommendations on how to transition these settings into full compliance with the new regulations. Please note that the analysis of existing support for each new regulation is only the first step in the assessment process. It has been used to identify where Idaho lacks documented support for the setting quality requirements. Idaho understands that more work is necessary to complete a full assessment of settings. "Section 2: State Assessment and Remediation Plan" identifies the work remaining to complete a thorough assessment. That process includes soliciting input from individuals who live in and use these settings, provider self- assessment, as well as on-site validation of compliance.

In summary, the state determined that there were gaps in support for some of the HCBS setting qualities in RALFs and/or CFHs. Identified gaps included: lack of standards, lack of IDAPA support, and lack of oversight/monitoring to ensure compliance. Planned remediation activities include: development of standards to address access "to the same degree as individuals not receiving Medicaid HCBS;" rule promulgation to incorporate support for HCBS setting qualities into IDAPA; and enhanced monitoring and quality assurance activities to ensure ongoing compliance. The table containing the provider owned or controlled residential settings gap analysis is located at:
http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=13

Due to the gaps identified above, Idaho is unable to say at this time how many residential settings fully align with the federal requirements, how many do not comply and will require modifications, and how many cannot meet the federal requirements and require removal from the program and/or relocation of participants. Proposed plans to complete a full assessment are outlined in Section Two. Medicaid must first enact regulatory changes to allow enforcement and then complete the assessment of individual settings. The assessment will occur in 2017.

Non- Provider Owned or Controlled Residential Settings

Idaho's residential habilitation services include services and supports designed to assist participants to reside successfully in their own homes, with their families, or in a CFH. Residential habilitation services provided to the participant in their own home are called "supported living" and are provided by residential habilitation agencies. Supported living services can either be provided hourly or on a 24-hour basis (high or intense supports).

As part of Idaho's outreach and collaboration efforts, Medicaid initiated meetings with supported living service providers in September 2014. The goal of these meetings was to ensure that supported living providers understood the new HCBS setting requirements, how the requirements will apply to the work that they do, and to address any questions or concerns this provider group may have. During these meetings, providers expressed concern regarding how the HCBS setting requirements would impact their ability to implement strategies to reduce health and safety risks to participants receiving high and intense supports in their own homes. Because of these risk reduction strategies, supported living providers are concerned that they will be unable to ensure that all participants receiving supported living services have opportunities for full access to the greater community and that they are afforded the ability to have independence in making life choices.

Since our initial conversations with residential habilitation agency providers the state has addressed provider concerns by obtaining clarification from CMS and publishing draft HCBS rules. Our goal is that through individualized supportive strategies created by the participant and their person-centered planning team, agencies will support participants in integration, independence, and choice while maintaining the health, safety, dignity, and respect of the participant and the community.

Although the HCBS regulations allow states to presume the participant's private home meets the HCBS setting requirements, the state will enhance existing quality assurance and provider monitoring activities to ensure that participants retain decision-making authority in their home. Additionally, the state is continuing to analyze the participant population receiving intense and high supported living and how the HCBS requirements impact them.

1b. Systemic Assessment of Non-Residential Service Settings

Idaho completed a preliminary gap analysis of its non-residential service settings in December 2014. The results of Idaho's analysis of its non-residential settings are summarized below, including an overview of existing support for each regulation. The state has included, where applicable, the full IDAPA rule citation(s) to identify where IDAPA supports the HCBS requirement, in addition to indicating if IDAPA is silent. The state did not identify any IDAPA rule that conflicts with the HCBS requirements. Additionally the chart includes preliminary recommendations to transition these settings into full compliance with the new regulations. Please note that the analysis of existing support for each new regulation is only the first step in the assessment process. It has been used to identify where Idaho lacks documented support for the setting quality requirements. Idaho understands that more work is necessary to complete a full assessment of settings. Section Three of this document identifies the work remaining to complete a thorough assessment. That process includes soliciting input from participants receiving services, provider self- assessment, as well as on-site assessment of compliance.

In summary, the state determined that there were gaps in support for some of the HCBS setting qualities for some of Idaho's non-residential services. Identified gaps included: lack of standards, lack of IDAPA support, and lack of oversight/monitoring to ensure compliance. Planned remediation activities include: development of standards to address congregate settings; development of standards to address access "to the same degree as individuals not receiving Medicaid HCBS;" rule promulgation to incorporate support for HCBS setting qualities into IDAPA; and enhanced monitoring and quality assurance activities to ensure ongoing compliance. A&D waiver services analyzed included: Supported Employment, Residential Habilitation, Day Habilitation, and Adult Day Health. These services may occur in Adult Day Health centers, Developmental Disability Agencies, or in the community. The table containing the non-residential service settings gap analysis is located at:
http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=23

Due to the gaps identified above, Idaho is unable to determine at this time how many non-residential settings fully align with the federal requirements, how many do not comply and will require modifications, and how many cannot meet the federal requirements and require removal from the program and/or relocation of participants

1c. Systemic Remediation

Idaho identified several tasks required for systemic remediation, including promulgating administrative rule to incorporate the HCBS setting qualities, enhancing existing monitoring and quality assurance activities, revising operational processes, and implementing operational changes.
The table containing the systemic remediation tasks, timeline, and status is located at:
http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=38

The systemic remediation work will be complete July 1, 2017.

It should be noted that Idaho follows a very prescriptive process of negotiated rulemaking and public noticing when promulgating IDAPA rules. For these changes the public was notified about upcoming regulatory changes in a variety of formats: the Department posted proposed changes, hosted various in-person and video conference meetings with the public to discuss changes, accepted comments on proposed rule language on more than one occasion, documented those

comments and modified rule language based on public comment. Information on upcoming rule changes was also published on the Idaho HCBS webpage with details on how to comment. In addition the STP published for comment in October 2014, the STP published for comment in January 2015 and the STP published for comment in September 2015 all identified that rules would be promulgated in the 2016 legislative session.

1d. Services Not Selected for Detailed Analysis

Several service categories did not have gaps related to HCBS setting requirements. The state has determined that many of our HCBS services are highly medical/clinical in nature, self-directed, for the purchase of goods/adaptations, provided by providers who have no capacity to influence setting qualities, or occur in settings which are analyzed elsewhere in the Transition Plan. Therefore, for these services, a detailed analysis was not necessary.

This includes the following services:

- Chore Services
- Environmental Accessibility Adaptations
- Home Delivered Meals
- Personal Emergency Response System
- Skilled Nursing
- Specialized Medical Equipment and Supplies
- Non-Medical Transportation
- Homemaker
- Attendant Care
- Companion Services
- Consultation
- Respite

Section 2: Analysis of Settings for Characteristics of an Institution

The Centers for Medicare and Medicaid Services has identified three characteristics of settings that are presumed to be institutional. Those characteristics are:

1. The setting is in a publicly or privately owned facility providing inpatient treatment.
2. The setting is on the grounds of, or immediately adjacent to, a public institution.
3. The setting has the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS.

Idaho completed an initial assessment of all settings against the first two characteristics of an institution in early 2015. At that time there were no settings where an HCBS participant lived or received services that were located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment. Further, there were no settings on the grounds of or immediately adjacent to a public institution.

Idaho has initiated its assessment of all settings for the third characteristic on an institutional setting: the setting has the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS. That process is described in detail in Section 2a and Section 2b.

Any setting identified as potentially institutional will receive a site visit by Department staff who will examine each site for all the characteristics of an institution. If the state determines a setting is HCBS compliant and likely to overcome the presumption of being an institution, those sites will be moved forward to CMS for heightened scrutiny. Any site unable to overcome this assumption will move into the provider remediation process.

The reader should note that much of this section of the State Transition Plan has been revised as the state has modified its strategy for analysis of settings for characteristics of an institution. Versions 1- 3 of the State Transition Plan contain all previous verbiage and can be found at: www.HCBS.dhw.idaho.gov .

2a. Analysis of Residential Settings for Characteristics of an Institution

Idaho Medicaid supports two types of residential settings for adults that needed to be analyzed against the characteristics established by CMS as presumptively institutional. They are CFHs and RALFs.

Certified Family Homes (CFHs)
In September of 2014 Department of Health and Welfare's health facility surveyors from the CFH program were asked to identify if any CFH was in a publicly or privately owned facility providing inpatient treatment, or on the grounds of or immediately adjacent to a public institution. Health Facility surveyors visit every CFH once a year so they have intimate knowledge of each physical location. No CFH was found to meet either of the first two characteristics of an institution.

In April 2016 that process was repeated with questions added related to isolation. Surveyors again reported that there are no CFHs that are in a publicly or privately owned facility providing inpatient treatment, or on the grounds of, or immediately adjacent to, a public institution. However, six CFHs were identified as potentially having the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS.

Residential Assisted Living Facilities (RALFs)

In early summer of 2014 Department of Health and Welfare's health facility surveyors from the RALF program were asked to identify if any RALF was in a publicly or privately owned facility providing inpatient treatment, or on the grounds of or immediately adjacent to a public institution. No RALFs were found to meet either of the first two characteristics of an institution.

In April 2016 that process was repeated with questions added related to isolation. It again found that no RALFs are in a publicly or privately owned facility providing inpatient treatment, or on the grounds of, or immediately adjacent to, a public institution. However, licensing and certification staff were unable to assess all RALFS for isolation. While the actual address and physical proximity of the sites to inpatient facilities or to a public institution had not changed, staff determined that they could only accurately assess each RALF for isolation if they had visited that RALF recently. As a result Idaho's assessment of RALFs for this third characteristic of an institution, that the setting has the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS, is not yet complete. Idaho expects to utilize a different process for assessing RALFS for this third characteristic. It is now proposed that any RALF not recently visited by licensing and certification staff and assessed by them for isolation, will receive an on-site visit between January 2, 2017 and June 30, 2017. This visit will specifically assess each RALF to determine if the setting has the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS.

2b. Analysis of Non-Residential Settings for Characteristics of an Institution

Idaho's non-residential HCB services by definition must occur in a participant's private residence, the community, in developmental disabilities agencies (DDAs), or in standalone adult day health centers. A setting in a participant's private residence or the community is presumed to be compliant with all HCBS requirements. For the non-residential service setting analysis, DDAs and adult day health centers were the two setting types examined.
In 2015 Medicaid solicited the help of Department of Health and Welfare staff responsible for completing the licensing and certification of DDA settings to assess those settings for the first two characteristics of an institution. Those characteristics are that they are in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. A list of all DDAs was created with two questions tied to the two above mentioned characteristics of an institutional setting. Licensing and certification staff who routinely visit those settings then answered the two questions about each specific DDA. No DDAs were found to be in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. In April 2016 that process was repeated with questions added related to isolation. No DDAs were found to have any of the three characteristics of an institution.

To assess adult day health centers against the first two characteristics of an institution, the Idaho Department of Health and Welfare staff responsible for the biannual provider quality reviews for all standalone adult day health centers were asked to identify any centers in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. No adult day health centers were found to be in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. In April 2016 that process was repeated with questions added related to isolation. No adult day health centers were found to have any of the three characteristics of an institution.

2d. Heightened Scrutiny Process

Any setting with a negative or 'unknown' response to the questions assessing the characteristics of an institution will be subject to further evaluation. This evaluation will include:

- A site visit to each setting by Medicaid staff to assess firsthand the settings characteristics to determine if the setting does or does not meet the characteristics of an institution
- A review of documented procedures for how participants access the broader community
- Barriers which are present at the setting to prevent or deter people from entering or exiting. Idaho will recognize exceptions to barriers utilized for safety measures for a particular individual.
- In residential settings the processes that are utilized to support social interactions with friends and family in the setting and outside of the setting.

The review of settings with a negative or 'unknown' response to the questions assessing the characteristics of an institution will be completed by June 30, 2017. Idaho will identify those settings it believes can overcome the assumption of being institutional and will submit evidence to CMS demonstrating such. This evidence will include such things as:

- Any documented procedures for how individuals access the broader community
- Logs which may be used for exiting or entering the setting
- Case notes on individual's activities
- Calendar of activities sponsored outside of the setting
- Documented procedures for outside visitors and outside phone calls, etc.

Settings the state believes are institutional and cannot overcome this assumption will be moved into the provider remediation process.

Section 3: Site-Specific Assessment and Site-Specific Remediation

Overview

Idaho will use a multi-component approach to assess all HCBS settings for compliance with the HCBS setting requirements. A summary of those components follows:

- Medicaid will complete a one-time site-specific assessment for a randomly selected and statistically valid sample of HCBS service providers, stratified by provider type. During those site visits each site will be assessed on all setting requirements and evidence of compliance will be examined. This work will begin on January 2, 2017 and be completed by December 31, 2017.
- At the same time, beginning January 2, 2017, Medicaid will start its ongoing monitoring of all sites for HCBS compliance. This simultaneous implementation of ongoing monitoring and the site-specific assessments will ensure that settings not selected for a site visit will still be assessed for compliance with HCBS setting requirements. Details for ongoing monitoring can be found in the Section 3d below.

Both the site-specific assessments and the ongoing monitoring work can potentially lead to discovery of a non-compliance issue. Discovery of non-compliance issues will result in remediation activities; see Section 3b for details on provider remediation.

In preparation for initiation of the site-specific assessment and resulting remediation work, the state has completed regulatory changes in IDAPA to support the HCBS setting requirements. Rule changes are effective July 1, 2016, and providers are given six months before enforcement actions begin. Idaho will begin its formal assessment of settings in January 2017, which is expected to take one year.

Tasks designed to assist the state in preparing for the assessment are currently underway. Activities include operational readiness tasks, materials development, staff training, and participant and provider training and communications, all of which will occur prior to the assessment start date of January 2, 2017. In addition, there have been numerous training opportunities for providers to date and the HCBS regulations have been shared.

The assessment plan described below in 3a covers provider owned or controlled residential and non-residential settings

that are not the participants' own home. These are settings in which providers have the capacity to influence setting qualities. The provider types and number of current setting are:

- Adult Day Health Centers – 53 service sites
- Developmental Disability Agencies – 75 service sites
- Certified Family Homes – 2,212 service sites
- Residential Assisted Living Facilities – 352 service sites

By January 1, 2018, all HCBS settings in Idaho will have been assessed for compliance with the HCBS setting qualities. While not all setting sites will receive an on-site assessment, all settings are subject to the ongoing monitoring activities that will be established by January 1, 2017 (see section 3d.). Data collected during ongoing monitoring activities will inform the state's determination of compliance vs. noncompliance of the settings not selected for an on-site assessment.

Section 3b describes the proposed plan for site-specific provider remediation. Section 3c describes Idaho's plan for relocating participants in non-compliant settings or with non-compliant service providers. Finally, Section 3d describes the ongoing monitoring plan and, includes all settings where Medicaid HCBS are delivered. While Idaho Medicaid presumes that services delivered in community settings or in a participant's private residence meet HCBS setting quality requirements, an ongoing monitoring system will ensure that Medicaid providers do not arbitrarily impose restrictions on setting qualities while delivering those services. Monitoring will be used to hold all providers of HCBS accountable for setting quality compliance and to ensure participant rights are honored.

Idaho Standards for Integration in All Settings

Idaho has worked extensively with providers, advocates, licensing and certification staff and Medicaid staff to understand what qualifies as appropriate community integration in residential and congregate non-residential service settings.

Initially Idaho intended to create standards for integration for both residential and non-residential HCBS settings. The goal was to ensure that stakeholders, providers, quality assurance/assessment staff and participants, understood what must occur in HCB service settings to meet the integration and choice requirements of the new regulations. After many meetings with stakeholders, standards were determined for residential settings. However, that task was more of a challenge for non-residential service settings. The services themselves are variable and many are clinical in nature. Idaho organized a series of meetings with stakeholders to discuss what standards for non-residential service settings should be. Ultimately it was determined that instead of having fixed standards for integration, a toolkit will be developed for providers that includes guidelines, instructions for completing a self-assessment, review criteria and best practices for integration. The guidance will be incorporated into all trainings for staff and providers. It will also be incorporated into the setting assessment to be completed in 2017 and be part of ongoing monitoring of these settings. Attachments 1 and 2 have thus been removed from the Transition Plan (v3). It is the state's intention to ensure that any self-assessment tool or documents developed as part of the toolkit appropriately assess if participants are or are not given the opportunity for community participation to the extent that they desire and in manner that they desire in that setting.

Integration relies heavily on interaction with peers. It is the state's intention to define "peers" as including individuals with and without disabilities. The state will make this clear in administrative rules and in any guidance materials it provides.

3a. Site-Specific Assessment

Idaho last submitted an updated Statewide Transition Plan to CMS on October 23, 2015. That plan included the assessment plan for Idaho HCBS services. The approach at that time employed a risk stratification methodology whereby all settings would initially be screened to assess compliance and to identify those settings most likely to have difficulty meeting the setting requirements.

Based on guidance provided by CMS through informational webinars and subsequent phone meetings, Idaho does not believe the approach published in October 2015 will meet the CMS standards for site assessments. As a result the information originally contained in this section has been deleted and replaced with an updated plan for assessing HCBS sites in Idaho for compliance. The deleted information is included on the HCBS webpage, www.HCBS.dhw.idaho.gov, in version 3 of the STP. Below is the new assessment process Medicaid intends to implement.

The proposed strategy and timeline for assessment includes the following activities:
Baseline Assessment of Settings: April 2016 – June 2016
o Idaho will complete a baseline assessment of HCBS settings between April and June of 2016.
o A data analyst from Medicaid will select a random sample of sites to take part in the baseline assessments. The sample size will include more sites than required to have a statistically significant sample, as participation will be voluntary.
o Staff will contact providers on the list to ask them if they would be willing to participate in the baseline assessment. If the provider agrees, a time will be scheduled to complete the assessment over the phone.
o Providers will be asked to identify over the phone what evidence they will provide to support their responses should they be selected for the official site-assessments scheduled to begin in January of 2017.
o All assessment results will be tracked and a summary report of compliance vs. non-compliance will be generated once the baseline work is completed.
o The information obtained from the baseline work will be used to;
- determine current levels of HCBS compliance in the provider community,
- inform the development of upcoming provider trainings,
- identify best practices for compliance,
- identify the types of evidence providers can maintain to validate compliance,
- modify the provider self-assessment tool and the on-site assessment tool if necessary,
- potentially identify additional materials needed for the provider toolkit,
- provide targeted technical assistance to those providers who have participated, and
- inform current plans for the site-assessments scheduled to begin in 2017.

Provider Self-Assessment: August 1, 2016 – December 31, 2016
o All HCBS providers will be given a provider self-assessment tool by August 1, 2016 and will be required to complete the self-assessment no later than December 31, 2016. This requirement is now supported in Idaho rule.
o Training will be offered to providers on how to complete the self-assessment and what best practices might look like.
o Providers will be informed they may be selected for on-site assessment beginning in 2017. At that time, providers would be expected to produce both a completed self-assessment and evidence to support each response. They will also be informed that they may be asked at any time in 2017 to submit their completed self-assessment and the evidence to support their responses to Medicaid for review should any concerns about their compliance arise during 2017. Concerns may be triggered either via a complaint or as a result of on-going quality assurance activities described below in Section 3d.
o All providers will be required to maintain a copy of the completed provider self-assessment specific to that location on site for all of 2017 along with the evidence to support each response.

Assessment of Compliance through Site-Specific Visits: January 1, 2017 – December 31, 2017
Beginning in January of 2017, Medicaid staff will visit a stratified random statistically valid sample of HCBS settings to complete an on-site assessment for HCBS compliance. Settings to receive a site assessment will be selected using the following process:
o The population for each provider type will be stratified among the three geodensity areas of Frontier, Rural, and Urban counties (Frontier < 7 person per sq. miles, Rural >= 7 person per sq. miles and does not have a population center of 20,000 or greater, Urban are those counties that have a least one population center of 20,000 or greater).
o The sample size of each strata will be based on the population size of each provider type and geodensity category selected with a 95% confidence level and a ± 10% confidence Interval/ margin of error.
o A data analyst from Medicaid will use the probability sampling type of stratified random sample for the population of providers. Random numbers will be generated and assigned by the auto-process of MS Excel's "Random Number Generator" tool from the "Data Analysis" feature.
o The sample for each strata will be selected by the ascending sort order of the random numbers. The providers not selected in each strata will be placed on a replacement list and will be selected as needed based on the ascending sort order of the random numbers.

The HCBS Coordinator will be responsible for overseeing the site-specific assessment process and for tracking the outcomes. Site–specific assessments will begin January 2, 2017 and will run through December 31, 2017. A site-specific

assessment tool has been developed for use during the site visits/assessments.

The team who will be completing the site-specific assessment has been identified. They will receive training on use of the site-specific assessment tool later this year. In addition to formal training, the assessment team members will be asked to participate in the baseline assessment work described above. This will allow them an opportunity to try the site-specific assessment tool in advance of the official assessment.

The site-specific assessments will be completed in person by state staff who will visit the identified sites specifically to assess HCBS compliance. Providers will be contacted in advance of the site-assessment visit and asked to have available their completed self-assessment and the evidence they have to support each response in that self-assessment. Once on site, the assessment team will utilize the site-specific assessment tool to assess compliance. The tool aligns directly with the provider self-assessment.

During the visit the assessor will document the provider's responses and the evidence the provider is offering to support the responses. The assessor will complete observations and/or follow-up questioning with providers or participants as needed to determine the status of the provider's compliance with all the HCBS requirements. The assessor will document the decision of compliance or non- compliance for each regulation and will note the rationale for the determination of compliance or non-compliance.

Within fifteen calendar days of each site-specific assessment, providers will be given the results of the assessment. If an issue of non-compliance has been identified the provider will also receive a request for a corrective action plan and be moved into the remediation process described in 3b below. All requests for a corrective action plan will include an offer for technical assistance on how to come into full compliance.

An HCBS Oversight Committee will be established in January, 2017. Members are expected to consist of staff, providers, advocates and participants or family members. The Committee will serve in an advisory capacity to support the HCBS Coordinator during the assessment process and ensure Idaho is fully compliant by March of 2019.

Beginning January 1, 2017, the HCBS Coordinator will report the status of the on-site assessments to the Oversight Committee and to CMS on a quarterly basis.

Following the completion of all provider site-assessments in December of 2017, a comprehensive report will be made and included in the state transition plan that addresses the results of all provider site-assessments. The following table outlines the number of site-assessments that are expected to be completed on a quarterly basis.

3b. Site Specific Remediation

To ensure provider compliance with HCBS rules, the state has provided extensive provider trainings that began in 2014 and will continue through the end of 2016. The state is developing a toolkit that providers can utilize to comply with the HCBS rules. Below is a description of Idaho's proposed provider remediation process that will be used to track and report on progress towards full compliance.
Any HCBS provider, residential or non-residential, found to be out of compliance with the HCBS setting requirements via the initial assessment or via ongoing monitoring activities will undergo the following proposed provider remediation process.

- If an HCBS rule violation is identified, the provider will receive a request for a Corrective Action Plan (CAP).
- CAPs will also be issued for any non-compliance issue identified during the monitoring of settings or complaints the department might receive.
- The provider will be given 45 days to implement the CAP. QA/QI staff will offer technical assistance to the provider to become fully compliant with HCBS rules throughout the CAP process. The provider will be required to submit documentation validating compliance to the QA/QI staff within 90 days of an approved CAP before the process can be determined complete.

The state has developed an HCBS-specific process with guidelines for enforcement of HCBS compliance. IDAPA 16.03.09.205.03 regulates agreements with providers and will be followed to ensure provider compliance with HCBS rule. This process will allow providers ample opportunity for compliance and allow the state time to support participants

who choose to consider alternative, compliant providers.

The HCBS Coordinator will be responsible for coordinating all remediation activities related to Home and Community Based Settings. The HCBS Coordinator, along with the QA/QI staff, is responsible for providing technical assistance to providers during the CAP process and enforcement actions as needed. Section 4: Major Milestones for Outstanding Work includes a table with the tasks and timeline for activities to specifically address remediation.

3c. Participant Relocation

Idaho Medicaid initially published a high-level plan on how the state will assist participants with the transition to compliant settings. The state has now developed a more detailed relocation plan. This plan describes how the state will deliver adequate advanced notice, which entities will be involved, how participants will be given information and supports to make an informed decision, and how it will ensure that critical services are in place in advance of the transition.

All providers will have been assessed for compliance on the HCBS rules by the end of December 2017. Non-compliant providers will be given the opportunity to remediate any HCBS concerns prior to April 2018 based on the corrective action plan timeline. If a provider fails to remediate or does not cooperate with the HCBS transition, provider sanction and disenrollment activities will occur. Any provider who is unable or unwilling to comply with the new rules cannot be reimbursed by Medicaid to provide care and assistance to HCBS participants. This will trigger the relocation process outlined below:

- If it is determined a setting does not meet HCBS setting requirements, the plan developer (the person responsible for the participant's person centered service plan) will notify the affected participants and their legal guardian(s), if applicable. The formal notification letter will indicate that their current service setting does not meet HCBS requirements and will advise participants to decide which of the following they prefer:
  - To continue receiving services from that provider without HCBS funding.
  - To continue receiving Medicaid HCBS funding for the services and change providers.

The participant will be asked to respond within 30 days from the date of the letter.

- The letter will further indicate that, if the participant wishes to continue receiving Medicaid HCBS funding for the service, he or she must select a new provider who is compliant with Medicaid HCBS rules. It will direct participants to the appropriate entity for assistance. Participants will then be given information on alternative HCBS compliant settings along with the supports and services necessary to assist them with this relocation.
- Once the participant has made his or her decision they will have 30 days to transfer to a new provider. An extension for up to six months may be offered if necessary to find alternative HCBS compliant care or housing. Extensions will be offered on a case-by-case basis in order to meet the participant's needs.
- The plan developer will revise the plan of service and follow the process of the specific program for authorizations. An updated person-centered plan will reflect the participant's choice of setting and services.
- The Department will send the current service provider a formal notification letter indicating that their Medicaid provider agreement will be terminated, and that participants served have been notified that the provider is not HCBS compliant. This notification will occur no less than 30 days prior to relocation or discontinuation of Medicaid funding for the service. The specific reasons will be included in the agency's formal notification. The current provider may be requested to participate in activities related to the relocation of the participant based on requirements identified in the specific program rules and the Medicaid Provider Agreement.
- Upon relocation to a new HCBS provider, any modifications or changes necessary for the person's health, safety, or welfare will be addressed in the new or revised person-centered plan of service.
- Medicaid will submit quarterly updates to CMS beginning in January, 2017 indicating the number of participants impacted by a non-compliant HCBS setting or provider and provide the general status of participant relocation activities.

3d. Ongoing Monitoring

Ongoing quality assurance activities will begin January 1, 2017. Those activities include:

- Existing participant feedback mechanisms will be modified to include targeted questions about HCBS compliance in the participant's service setting. There are four tools used at Medicaid: the Children's Service Outcome Review (CSOR) which is used to assess services provided to Children's DD waiver and Act Early waiver participants, the Adult Service Outcome Review (ASOR) and Participant Experience Survey (PES) which is used to assess services provided to Adult DD waiver participants, and the Nurse Reviewer Home Visit form, which is used to assess services provided to A&D waiver and State Plan Personal Care Services participants.

- Existing Provider Quality Review processes will be modified to include components specific to HCBS compliance.
- Existing complaint and critical incident tracking and resolution processes will be modified to include an HCBS setting quality category.
- Licensing and Certification staff will be assessing compliance with some of the HCBS requirements when completing their routine surveys of Certified Family Homes, Developmental Disability Agencies and Residential Assisted Living Facilities. They will continue to cite on requirements that are included in their rules, and will notify the respective Bureau's Quality Assurance Specialist if issues with other HCBS requirements are identified. The Bureau's Quality Assurance Specialist will investigate and document the compliance issue in the same manner as a complaint. Ongoing issues or trends will be reported to the Oversight Committee through March, 2019. Once Idaho has reached full compliance, issues or trends related to HCBS compliance will become part of existing quality monitoring management mechanisms. At that time the role of the Oversight Committee will be reassessed.

The chart illustrating the major steps for coming into compliance with HCBS rules is located at:
http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=52

Section 4: Major Milestones for Outstanding Work
In the initial versions of the Idaho State Transition Plan Idaho included tasks for reaching compliance along with a task description and timeline. In version 4 of the STP those tasks have been moved to Attachment 5, Task Details. Only major milestones remain in the body of the STP. The tasks will continue to be updated in the attachment, but readers can find the major milestones for outstanding work and the associated timelines here. Quarterly updates on the status of incomplete work will be provided to CMS based on these milestones. The tables containing the remaining major milestones can be found at:

http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=53

Major steps and timeline for moving to full compliance include:
1) Systemic remediation: completed by June 2017
2) Analysis of settings for characteristics of an institution: completed by June 2017
3) Site-specific assessment: beginning January 2017, completed by December 31, 2017
4) Site-specific remediation and participant relocation: beginning as early as January 2017, completed by March 2019
5) Statewide Transition Plan revisions: completed by May 2018

Section 5: Public Input Process

The public input process, including a summary of comments received during the state's prior public comment periods and responses to those public comments can be found at:

http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=58
Attachments

Attachment 1: Proof of Public Noticing (located at:
http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=67)

Attachment 2: Public Comments to the Idaho HCBS Settings Transition Plan Posted in October 2014 (located at:
http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=102)

Attachment 3: Public Comments to the Idaho HCBS Settings Transition Plan Posted in January 2015 (located at:
http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=118)

Attachment 4: Public Comments to the Idaho HCBS Settings Transition Plan Posted in September 2015 (located at:
http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=140)

Attachment 5: Task Details (located at:

http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=155)

Attachment 6: Idaho Response to CMS Request for Additional Information (located at: http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdfXpage=165)

Attachment 7: Index of Changes (located at http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page =170)

[Sections Omitted]

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Character Count: 6289 out of 12000

~~The following is the method that is employed to establish provider payment rates for waiver services:~~

~~The Department solicits comments at public hearings when administrative rules related to rate determination methods are promulgated. Administrative rules are published when there are changes to rate determination methods. The public may submit comments on these rules for 21 days after the date of publishing. Pursuant to 42 CFR §447.205, the Department gives notice of its proposed reimbursement changes by publishing legal notices throughout the State to inform providers about any change. Additionally, payment rates are published on our website at www.healthandwelfare.idaho.gov for participants to access.~~The Department provides public notice of significant reimbursement changes in accordance with 42 CFR § 447.205 (made applicable to waivers through 42 CFR § 441.304(e)). The Department publishes public notice of proposed reimbursement changes in multiple newspapers throughout the State and on the Department's website at www.healthand welfare.idaho.gov. Copies of public notices are made available for public review during regular business hours at any regional or field office of the Idaho Department of Health and Welfare and any regional or local public health district office. In Adams, Boise and Camas counties, copies of the amendments will be available at the county clerk's office in each of these counties. Additionally, payment rates are published on our website at www.healthandwelfare.idaho.gov for the public to access.

The Department provides opportunity for meaningful public input related to proposed reimbursement changes in accordance with 42 CFR § 441.304(f). The Department solicits comments from the public (including beneficiaries, providers and other stakeholders) through its public notice process and through public hearings related to the proposed reimbursement changes. The public is given the opportunity to comment on the proposed reimbursement changes for at least 30 days prior to the submission of a waiver amendment to CMS. Additionally, when administrative rules are promulgated in connection with reimbursement changes, the proposed rules are published in the Idaho Administrative Bulletin and the public is given the opportunity to comment.

Waiver service providers will be paid on a fee~~-~~for~~-~~service basis as established by the Department depending on the type of service provided. The Bureau of Financial Operations is responsible for rate determinations. The Department will ensure that the MCE reimburses providers at a rate no less than the current Medicaid Provider rates.

Please see below for services and reimbursement methodology information:

Adult Day Health, Home Delivered Meal Services, and Chore Services. The initial rate was set in 1999 based on time studies in nursing facilities.

Consultation Services, Companion Services, Chore Services, Homemaker Services, Respite Care Services, Personal Emergency Response System Services, ~~Residential Habilitation,~~ Day Habilitation and Supported Employment - The initial rate was set back in 1999 based on time studies in nursing facilities. Going forward, the rate is set based on a labor model that uses a Staff Support Hour (SSH) rate approach, which involves developing a single rate for a unit of staff time spent providing services for an individual.

Adult Residential Care - This service is paid on a per diem basis based on the number of hours and types of assistance required by the participant as identified in the Uniform Assessment Instrument.

Non-medical Transportation - A study is conducted that evaluates the actual costs of fuel reasonably incurred by the typical non-commercial transportation provider whose personal vehicle averages fifteen (15) miles per gallon.

Specialized Medical Equipment & Supplies - For codes that are manually priced, including miscellaneous codes, a copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer is required. Reimbursement will be seventy-five percent (75%) of MSRP. If pricing documentation is the invoice, reimbursement will be at cost plus ten percent (10%), plus shipping (if that documentation is provided). For codes that are not manually priced, the rate is based on the Medicaid fee schedule price.

Environmental Accessibility Adaptations - For adaptations over $500, three bids are required if it is possible to obtain three bids. The lowest bid which meets the participant's needs is selected.

Attendant Care & Nursing Services - These services are paid on a uniform reimbursement rate based on an annual survey conducted by the Department.

Residential Habilitation:
The rate was developed as a result of a cost survey conducted in2016. The surveyed results of four cost components were combined to arrive at an hourly unit rate. The cost components are direct care wages, employee related expenditures, program related costs, and general and administrative costs as identified in Idaho Administrative Code 16.03.10.037.04 published athttps://adminrules.idaho.gov/rules/current/16/0310.pdf . The stated administrative rule is effective for services on or after 04/04/13.

The detailed reimbursement methodology and hourly unit rate calculation can be found at http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/SupportedLivingReport.pdf. The hourly unit rate is used for calculating all Residential Habilitation reimbursements, and these are listed on the fee schedule. The current fee schedule and any annual/periodic adjustments to the fee schedule are published at www.healthandwelfare.idaho.gov. The fee schedule is effective for services on or after 04/03/17.

The contract between the Department and the MCE shall be a firm fixed fee, indefinite quantity contract for services specified in the Scope of Work. For payment purposes, a capitated payment is calculated based on the current eligible MMCP participant count multiplied by the per member per month (PMPM) figure and is intended to be adequate to support participant access to, and utilization of covered services, including administrative costs. The total PMPM payment is comprised of two (2) components; the Medical capitation and the blended Long Term Services and Supports (LTSS). Once the eligible Enrollee count by enrollment status is determined for the contract, the blended LTSS rate will remain in effect through the contract period.

[Sections Omitted]

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one*:

☒ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

☐ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one*:

☒ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

☐ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one*:

☒ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

☐ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

a) In 2014 after the completion of a readiness review, and no sooner than June 1, 2014, the MCE that has already operated the MMCP since 2007 will begin furnishing waiver services.

b) Effective January 1, 2017, the geographic area served will be following 22 counties: Ada, Bannock, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Cassia, Clark, Elmore, Fremont, Gem, Jefferson, Kootenai, Madison, Minidoka, Nez Perce, Owyhee,

Payette, Power, Twin Falls~~The geographic area served will be following 42 counties: Ada, Adams, Bannock, Bear Lake, Benewah, Bingham, Blaine, Boise, Bonner, Bonneville, Boundary, Butte, Camas, Canyon, Caribou, Cassia, Clark, Clearwater, Custer, Elmore, Fremont, Gem, Gooding, Idaho, Jefferson, Jerome, Kootenai, Latah, Lewis, Lincoln, Madison, Minidoka, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Teton, Twin Falls, Valley, and Washington~~

c) Covered services will include all Medicaid services the participants are eligible for, except for the following services: Developmental Disabilities Waiver services, Developmental Disabilities 1915(i) state plan services, and non-emergency medical transportation, which will continue to be offered via Medicaid fee-for-service.

d) Capitated payments to the MCE are processed through the Department's MMIS system and are sent to the MCE on a monthly basis.

☐ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

☐ **This waiver is a part of a concurrent 1115/1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

[Sections Omitted]

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							364502.98
Adult Day Health	☐	Per 15 Minute Ur	140	1414.99	1.84	364501.42	
Adult Day Health MMCP	☑	Per Member Per	13	12.00	0.01	1.56	
Day Habilitation Total:							54471.43
Day Habilitation	☐	Per 15 Minute Ur	3	3259.81	5.57	54471.43	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation MMCP	☑	Per Member Per	0	12.00	0.01	0.00	
Homemaker Total:							3271451.66
Homemaker	☐	Per 15 Minute Ur	6224	129.46	4.06	3271381.70	
Homemaker MMCP	☑	Per Member Per	583	12.00	0.01	69.96	
Residential Habilitation Total:							1683860.72
Residential Habilitation	☐	Per Diem	23	289.11	253.23	1683860.48	
Residential Habilitation MMCP	☑	Per Member Per	2	12.00	0.01	0.24	
Respite Total:							212898.76
Respite	☐	Per 15 Minute Ur	106	617.99	3.25	212897.56	
Respite MMCP	☑	Per Member Per	10	12.00	0.01	1.20	
Supported Employment Total:							0.00
Supported Employment	☐	Per 15 Minute Ur	0	0.00	6.46	0.00	
Supported Employment MMCP	☑	Per Member Per	0	12.00	0.01	0.00	
Attendant Care Total:							88673790.30
Attendant Care	☐	Per 15 Minute Ur	6516	2846.99	4.78	88673717.10	
Attendant Care MMCP	☑	Per Member Per	610	12.00	0.01	73.20	
Adult Residential Care Total:							76593662.88
Attendant Care	☐	Per Diem	4950	272.42	56.80	76593607.20	
Adult Residential Care MMCP	☑	Per Member Per	464	12.00	0.01	55.68	
Chore Service Total:							195838.30
Chore Service	☐	Per 15 Minute Ur	417	144.50	3.25	195833.62	
Chore Service MMCP	☑	Per Member Per	39	12.00	0.01	4.68	
Companion Services Total:							1629988.89

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Companion Services	☐	Per 15 Minute Ur	378	1246.28	3.46	1629984.69	
Companion Services MMCP	☑	Per Member Per	35	12.00	0.01	4.20	
Consultation Total:							192829.07
Consultation	☐	Per 15 Minute Ur	3639	5.63	9.41	192788.03	
Consultation MMCP	☑	Per Member Per	342	12.00	0.01	41.04	
Environmental Accessibility Adaptations Total:							157408.63
Environmental Accessibility Adaptations	☐	Per Job	32	1.35	3643.71	157408.27	
Environmental Accessibility Adaptations MMCP	☑	Per Member Per	3	12.00	0.01	0.36	
Home Delivered Meals Total:							5147005.61
Home Delivered Meals	☐	Per Meal	3058	261.76	6.43	5146971.17	
Home Delivered Meals MMCP	☑	Per Member Per	287	12.00	0.01	34.44	
Non-medical Transportation Total:							368334.76
Non-medical Transportation	☐	Per Mile	1340	509.01	0.54	368319.64	
Non-medical Transportation MMCP	☑	Per Member Per	126	12.00	0.01	15.12	
Personal Emergency Response System Total:							990998.85
PERS Monthly Rent	☐	Per Month	2497	9.21	41.61	956920.57	
PERS Installation and 1st Month Rent	☐	Per Month (+ Ins	553	0.88	69.97	34050.20	
Personal Emergency Response System MMCP	☑	Per Member Per	234	12.00	0.01	28.08	
Skilled Nursing Total:							2272032.22
Nursing Supervisory Visits	☐	Per Visit	3766	4.72	48.26	857846.60	
RN Nursing Services	☐	Per 15 Minute Ur	170	530.90	9.41	849280.73	
LPN Nursing Services	☐	Per 15 Minute Ur	42	2101.42	6.40		

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						564861.70	
Skilled Nursing MMCP	☑	Per Member Per	360	12.00	0.01	43.20	
Specialized Medical Equipment and Supplies Total:							107889.62
Specialized Medical Equipment and Supplies	☐	Per Piece of Equ	118	1.02	896.38	107888.30	
Specialized Medical Equipment and Supplies MMCP	☑	Per Member Per	11	12.00	0.01	1.32	

GRAND TOTAL:	181916964.68
Total: Services included in capitation:	374.28
Total: Services not included in capitation:	181916590.40
Total Estimated Unduplicated Participants:	12106
Factor D (Divide total by number of participants):	15027.01
Services included in capitation:	0.03
Services not included in capitation:	15026.98
Average Length of Stay on the Waiver:	277