

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:**
Children's Developmental Disabilities Waiver
- C. **Waiver Number: ID.0859**
- D. **Amendment Number: ID.0859.R01.01**
- E. **Proposed Effective Date:** (mm/dd/yy)

07/01/16

Approved Effective Date: 07/01/16

Approved Effective Date of Waiver being Amended: 07/01/14

2. Purpose(s) of Amendment

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

The purposes of this amendment to the Idaho Children's Developmental Disability (DD) Waiver are as follows:

1. To align DD waiver performance measures with the updated CMS sub-assurance and to ensure performance measures reflect current data source and sampling practices. The Department is also taking this opportunity to ensure that performance measures are aligned across Idaho's HCBS waivers.
2. To conduct a thorough review of waiver language to ensure it is consistent with current operational practices, including service plan development and complaint/critical incident systems, and to ensure alignment with recent Idaho Administrative Procedures Act (IDAPA) changes in response to the Home and Community-Based Services Final Rule.

The State assures the implementation of any required changes that may occur upon the approval of the Statewide Transition Plan and will make conforming changes to this waiver application when it submits the next amendment.

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)
<input checked="" type="checkbox"/> Waiver Application	2. Brief V
<input checked="" type="checkbox"/> Appendix A – Waiver Administration and Operation	Quality Ii
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	Quality Ii
<input checked="" type="checkbox"/> Appendix C – Participant Services	1. Participi
<input checked="" type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	1. Service
<input checked="" type="checkbox"/> Appendix E – Participant Direction of Services	1. Overvi
<input type="checkbox"/> Appendix F – Participant Rights	
<input checked="" type="checkbox"/> Appendix G – Participant Safeguards	2. Safegu
<input type="checkbox"/> Appendix H	
<input checked="" type="checkbox"/> Appendix I – Financial Accountability	Quality Ii
<input type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	

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:

Additions specific to final HCBS regulations; revisions to quality performance measures; and adjustments to language specific to state HCBS rules contained in IDAPA 16.03.10.

Minor corrections to text for accuracy and to eliminate extraneous characters throughout the document.

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Children's Developmental Disabilities Waiver

C. Type of Request: amendment

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

- 3 years 5 years

Waiver Number: ID.0859.R01.01

Draft ID: ID.007.01.01

D. Type of Waiver (*select only one*):

Regular Waiver

- E. **Proposed Effective Date of Waiver being Amended: 07/01/14**
Approved Effective Date of Waiver being Amended: 07/01/14

1. Request Information (2 of 3)

- F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR §§440.40 and 42 CFR §§440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

- G. **Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

- §1915(b)(1) (mandated enrollment to managed care)
- §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)

- A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

- A program authorized under §1915(i) of the Act.**
- A program authorized under §1915(j) of the Act.**
- A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

- This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Idaho offers waiver services to eligible participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration.

The purpose of the Children's DD waiver is to support children and youth, ages 0 - 17, to remain in their family home and in the community. The programs key elements include an array of therapeutic interventions, support services, and family training and education.

The primary objective of the Children's DD program is to incorporate family involvement into all aspects of their child's services and to achieve lasting positive outcomes. To accomplish this, families partner with professionals in order to design and implement interventions that will work best for them and their child. Eligibility determinations are completed by an Independent Assessment Provider (IAP) contracted with the Department. Once a child is determined eligible for waiver services, they are contacted by the Department who will educate families on the array of services available to them and will assign the family a case manager to help them begin the planning process.

In accordance with regulations contained in Idaho Administrative Code - IDAPA 16.03.10., Home and Community-Based Services (HCBS) rules, a paid or non-paid person who, under the direction of the participant or their decision-making authority, is responsible for developing a single plan of service and subsequent addenda. The family can write the plan themselves, choose a non-paid plan developer or utilize the assigned case manager to be their plan developer. The plan developers role will be to assess the child and family's needs through a family-centered planning process. This process will assist the plan developer to develop a plan of service based on the family's wants and skill level. The service plan must cover all services and supports identified during the family-centered planning process and must meet the HCBS person-centered plan requirements as described in IDAPA rules previously identified. Once the program is implemented, the plan developer will be responsible for tracking progress and ensuring the child is receiving appropriate services with positive outcomes.

Idaho functions as a single state agency. With regard to the organizational structure, the State of Idaho's Children's DD Waiver is managed by the Division of Medicaid in conjunction with the Division of Family and Community Services (FACS) within the Idaho Department of Health and Welfare. All aspects of the waiver are directly managed by the state.

Service providers that offer direct services are subject to the terms of a provider agreement specific to their provider type and specialty.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- Yes. This waiver provides participant direction opportunities.** Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable**
- No**
- Yes**
- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- No**
- Yes**
- If yes, specify the waiver of statewide that is requested (*check each that applies*):
- Geographic Limitation.** A waiver of statewide is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
- Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the

waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that

a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
Public input is a key element in the development and operation of the Act Early waiver. The Department has solicited public input in a variety of ways:
- 1) Tribal solicitations were mailed to the Tribal Representatives on 1/4/16, 1/22/16 and 2/2/16. In addition, ongoing feedback is solicited from Tribal representatives during the quarterly Tribal Meetings.
 - 2) The Department has sought informal public input regarding the assessment and planned implementation of the HCBS Final Rule requirements over the course of the last two years in multiple meetings and formats. The Department hosted 8 informational webinars between July 2014 and April 2015; 9 teleconference workgroups between August 2014 and April 2015; and 29 in-person meetings with advocates, providers, and other interested parties between January 2015 and December 2015. In addition, stakeholders have been invited to submit comment on the Idaho Statewide Transition Plan, which includes planned changes to waiver operations to align with the HCBS final rule, on three different occasions in October 2014, January 2015, and September 2015.
 - 3) The Department sought formal public input on proposed changes to rules for Idaho's HCBS waivers that align the Idaho Administrative Procedures Act (IDAPA) with the setting quality and person-centered planning requirements described in the HCBS Final Rule. A Negotiated Rulemaking meeting was held on 6/26/15, during which questions and formal comments were accepted. Stakeholders were invited to submit comments from 6/3/15-7/8/15. Stakeholders were also provided an opportunity to review and comment on a revised draft of the rules in September 2015. Public hearings regarding the new rules were held in Boise (10/19/15), Idaho Falls (10/19/15), and Coeur d'Alene (10/20/2015) – public comment during this time period was accepted from October 7 through October 28.
 - 4) A solicitation for public input regarding upcoming Idaho HCBS waiver amendments was created 2/25/16. The Department hosted an in-person public input meeting on 3/4/2015 to present an index of proposed waiver changes and to engage in an open discussion. Teleconferencing was available to individuals who could not attend in person. Notices of the public meeting were distributed by mass email, posted on the Health and Welfare website, included in the Medicaid newsletter for providers, and posted in each of the seven regional Medicaid offices and at the Central Office location. Stakeholders and interested parties were invited to provide formal comment through March 26, 2016. Feedback was received during the public comment period. No changes were made to draft amendment language as a result of this public feedback.
- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients

Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Idaho**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Idaho**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

HettingL@dhw.idaho.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

Dea Kellom

State Medicaid Director or Designee

Submission Date:

Aug 4, 2016

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

Kellom

First Name:

Dea

Title:

Medicaid Director Designee

Agency:

Department of Health and Welfare - Division of Medicaid

Address:

P.O. Box 83720

Address 2:

City:

Boise

State:

Idaho

Zip:

83720-0009

Phone:

(208) 364-1836

Ext:

 TTY

Fax:

(208) 364-1811

E-mail:

kellomd@dhw.idaho.gov

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:

N/A

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 HCBS 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.

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 gap analysis of existing support for the new HCBS regulations
- A plan for assessment and monitoring of all residential and non-residential service settings
- Initial plans for remediation of providers and relocation for impacted participants
- 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 on August 10, 2015, in the form of a letter. The state has since developed responses to the comments and also incorporated changes into the Transition Plan to address concerns identified. The CMS letter, along with the state's responses, has 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. 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 5).

Section 1: Results of Idaho Medicaid's Initial Analysis of Settings

Idaho completed 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. The results of the analysis of residential settings were shared with stakeholders via a WebEx meeting on September 16, 2014. The results of the 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 a list of service settings 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 Children's DD Waiver include: Developmental Disability Agencies (DDAs), 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/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=7>

1a. Gap Analysis of Residential Settings

The Children's DD waiver does not offer any HCBS services in a provider owned or controlled residential settings. 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.

1b. Initial Analysis of Settings Presumed to be Institutional

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 has completed its assessment of all settings against the first two characteristics of an institution. There are no settings where an HCBS participant lives or receives services that are located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment. Further, there are no settings on the grounds of or immediately adjacent to a public institution. Idaho will assess all settings against the third characteristic of an institution as part of its larger

assessment effort in 2017. At this point in time Idaho has no plans to request the heightened scrutiny process for any HCBS setting.

Analysis of Residential Settings Presumed to be Institutional

The Children's DD waiver does not offer any HCBS services in a provider owned or controlled residential setting. The State performed analysis work in relation to the public institution criteria for the two applicable adult waivers and described this analysis work in the submitted Transition Plan (v3).

Analysis of Non-Residential Settings Presumed to be Institutional

As of the publication of the Transition Plan (v3), Idaho's assessment of non-residential HCBS settings against two of the characteristics of settings presumed to be institutional is complete. There are no non-residential HCBS settings that are in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. Below is a description of the assessment process that led to this conclusion.

Non-residential Children's DD waiver services by definition must occur in a participant's private residence, in the community or in developmental disabilities agencies (DDAs). 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 were examined.

To assess the DDAs against the first two qualities of an institution, (in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution) Medicaid solicited the help of staff responsible for completing the licensing and certification of those settings. A list of all DDAs was created with two questions tied to the two above mentioned characteristics of an institutional setting. Licensing and Certification (L&C) 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.

Idaho will assess all settings against the third characteristic of an institution as part of its larger assessment effort in 2017. That characteristic is: Does this setting have the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS? Details of the assessment process are outlined in Section 2.

At this point in time Idaho does not intend to request the heightened scrutiny process for any HCBS setting.

Idaho Standards for Integration in All Settings

Idaho has worked extensively with providers, advocates, L&C 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 much 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. 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.

1c. Gap Analysis 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 Two 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 validation 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. Children's DD waiver services analyzed included: Habilitative Supports and Habilitative Intervention. These services may occur in Developmental Disability Agencies, in a private home, 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/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=21>

Due to the gaps identified above, Idaho is unable to say 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. 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.

Services Not Selected for Detailed Analysis

Several service categories from the Children's DD waiver 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.

For the Children's DD waiver this includes the following services:

- Family Education
- Crisis Intervention
- Family Training
- Therapeutic Consultation
- Respite

Section 2: State Assessment and Remediation Plan

The state is currently moving forward with regulatory changes in IDAPA to support the HCBS setting requirements. Rule changes are expected to become effective July 1, 2016, and providers will be given six months to become fully compliant. Idaho will begin its formal assessment of settings in January of 2017. It is expected to take one year. The state is not waiting until regulatory changes are enacted to prepare staff, participants, and providers for the coming changes or for the assessment activities.

Tasks designed to assist the state in preparing for the assessment are currently underway and others will be completed in 2016. All tasks have been added to the current task lists found below. 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 2017. In addition, there have been numerous training opportunities for providers to date and the HCBS regulations have been shared. Providers have the information they need to begin to make any needed changes to be compliant.

2a. Plan for Assessment and Ongoing Monitoring of Residential and Non-Residential Settings

Idaho Medicaid has developed a preliminary plan for assessment and ongoing monitoring of residential and non-residential settings where HCBS are delivered in order to ensure compliance with the new setting requirements. The proposed constellation of activities is a budget-neutral option that has been approved by Medicaid administration in collaboration with the Division of Licensing and Certification. The plan is divided into two stages: an initial assessment of residential and non-

residential settings to determine their current level of compliance and an ongoing system of monitoring those settings to ensure continuous compliance. This approach employs a risk stratification methodology whereby all settings will be initially screened to assess initial compliance and to identify and address those settings most likely to have difficulty meeting the setting requirements. Those least likely to have difficulty meeting the setting requirements will be passively monitored to ensure compliance during the later stage of implementing monitoring activities. This proposal achieves a balanced approach to demonstrating compliance by phasing in cost-neutral changes that will minimize impact to existing Department operations while ensuring Idaho's HCBS participants have an experience that meets the intent of the HCBS regulations for integrated community living.

During the development of the initial assessment plan and plan for on-going monitoring, it was determined that additional resources were needed to effectively manage the proposed operational changes. A full-time position has been used to hire an HCBS coordinator to oversee all HCBS assessment and monitoring activities.

The state will establish an assessment and monitoring oversight committee. Membership on this committee is not yet finalized. This entity will meet with the HCBS Coordinator once a month beginning in August 2016. Responsibilities of the oversight committee will include problem solving for issues related to determination of non-compliance and/or termination of a provider agreement. This group will also be responsible to ensure participants wanting to transition to a new service provider are given the support they need to do so successfully. The committee will address any challenges to the proposed processes for assessment, monitoring, remediation, and/or needed process or program changes.

The assessment and monitoring plan includes non-residential settings in which providers have the capacity to influence setting qualities. This includes:

- Developmental Disability Agencies – 75 service sites

Data collected during routine site visits, in conjunction with additional assessment information as described below, will be centrally warehoused to permit the Department to identify and cross-reference any trends or problems and will assist Idaho Medicaid in assessing initial and ongoing compliance of all settings. This multifaceted approach allows for a more robust mechanism of assessment than relying solely on one avenue for assessment.

One-Time Assessment

Idaho will implement a one-time assessment process to determine the initial level of compliance with the setting requirements by HCBS providers. That process will begin with the passage of state rule changes to support the HCBS regulations during the 2016 legislative session. Those rules are anticipated to become effective July 1, 2016, and providers will then be permitted six months to come into full compliance. The one-time assessment will be completed by December 2017. The assessment activities will include the following:

- Provider Self-Assessment

- o A provider self-assessment will be sent electronically to all HCBS providers in July 2016. It will identify the HCBS requirements and request providers to identify if they are or are not currently complying with the requirements. If they are not currently compliant they will be asked to provide their plan for coming into full compliance, along with their timeline for doing so. Submission of a completed provider self-assessment will be mandatory. Providers will be given until August 31, 2016, to submit the completed document.

Full compliance is required by January 1, 2017. Training will be offered to providers prior to the self-assessment being sent out to address any questions providers may have. The training will also address how to develop an acceptable transition plan should their setting not yet be in compliance with the new setting requirements. The state will assess all submitted transition plans. The plan will either be approved or the state will work with the provider to revise it until it is deemed an acceptable plan. If the provider is unable or unwilling to create an acceptable plan to transition to full compliance, that provider will be moved into the remediation process.

- Validation of Provider Self-Assessment

- o Under the oversight of the HCBS Coordinator, quality assurance staff from the BDDS, Family and Children's Services (FACS), and the Bureau of Long Term Care (BLTC) will review provider self assessments that indicate the provider will need a transition plan to come into compliance. Staff will approve provider transition plans based on agreed upon criteria and follow up with the provider to ensure activities identified in the plan are completed on time.

- o Rule violations related to HCBS will be identified during existing quality assurance (QA) activity or through participant or Licensing and Certification complaints.

- o The Licensing and Certification staff members will be oriented to the HCBS setting qualities and will validate the provider self-assessment during routinely scheduled Licensing and Certification surveys. The surveyors will continue to cite providers

for violations of requirements that already exist under their purview using existing processes. If Licensing and Certification staff observe violations of other HCBS requirements, these will be reported to Medicaid QA staff to be investigated in the same fashion that other complaints are processed.

- o On-site HCBS-specific compliance reviews will be completed the first year of rule implementation on a representative sample of all HCBS providers. This will be a one-time activity to assist with transitioning existing providers to compliance.
- o New providers would be expected to comply at the time of Medicaid enrollment and HCBS requirements would be assessed at their six-month review.

- Acknowledgement of Understanding

- o Every service plan development process following rule promulgation in 2016 will include a discussion related to the setting requirements. The participant will be supplied with supporting information about the requirements, including a “These are Your Rights” document. As part of this process participants will also be informed that they can file a complaint if any of the requirements are not met and provided information on how to do so. Both the participant and the provider(s) responsible for implementing the service plan will then be asked to sign an acknowledgement that they have been informed of the new setting requirements and the participant’s rights under these regulations. The QA staff will ensure signed documents are retained in the appropriate file using existing QA case file audit processes when applicable.

- Participant Feedback

- o Medicaid will modify existing participant experience measures in the Participant Experience Survey, and Children’s Service Outcome Review to include questions that assess qualities of the participant’s non-residential settings. Reported violations of HCBS setting requirements will be identified and investigated using the existing quality assurance protocols.

- o Feedback from participants will be reviewed as it becomes available from advocate groups and university research entities. Idaho Medicaid has been and will continue to work closely with the Idaho DD Council and the University of Idaho to support planned participant input activities to be led by the council. Currently the council is conducting face-to-face interviews with 240 participants to determine the existing level of compliance with HCBS requirements in the settings in which they reside and/or receive HCB services. This will serve as a baseline. The process will be repeated after Idaho completes its initial assessment in 2017 to determine, in part, implementation success. Any participant feedback collected in this manner will be provided to Medicaid in an electronic format that allows for data compilation and analysis.

- o Medicaid will develop an HCBS-specific participant survey that will be sent to a random sample of participants in January of 2017 asking them to assess the setting in which they are living and/or receiving HCBS against the HCBS requirements. All setting types will be included in the sample. This survey will allow Medicaid to receive feedback from participants regarding setting compliance with the non-residential setting requirements prior to the provider’s routinely scheduled quality assurance or licensing review.

Ongoing Monitoring

The ongoing monitoring of non-residential settings for continuous compliance with the HCBS setting requirements will begin after the initial year of assessment, approximately January 1, 2018. It will continue indefinitely and will be modified as needed. Ongoing monitoring will include the following activities:

- Acknowledgement of Understanding

- o Each year during the person-centered planning process, the participant and provider(s) responsible for implementing the service plan will be asked to acknowledge their understanding of HCBS requirements. This will be monitored by QA staff using existing QA case file audit processes when applicable.

- Compliance Surveys and Quality Reviews

- o The L&C staff members will be oriented annually to the HCBS setting qualities. For those providers who require a certification (Developmental Disabilities Agencies (DDAs)), L&C surveyors will continue to cite providers using existing processes for violations of requirements that already exist under their rule authority. If L&C observes violations of other HCBS requirements during routine L&C surveys, the violation will be reported to Medicaid or FACS QA staff to be investigated in the same fashion that other complaints are processed.

- o The FACS QA staff will be educated annually on the HCBS setting qualities to ensure they can identify and report potential violations of setting requirements that they observe during participant outcome reviews or provider surveys and continue to cite providers using existing processes for violations. Educational materials will be developed and made available to support training of new staff.

- o The QA managers from FACS will assume responsibility for ongoing monitoring of non-residential setting qualities. They will ensure the following as part of the routine QA activities:

- o Complaints are addressed from participants, guardians or advocates, service coordinators, care managers, informal observations from bureau staff, or L&C staff regarding potential setting requirement violations using the existing complaints and critical incidents protocols.

Participant experience measures are reviewed to identify and investigate potential setting requirement violations via the same protocols as for other program requirement violations.

The QA staff from the alternate bureaus will communicate with each other on assessment and monitoring of HCBS setting qualities to ensure consistency and facilitate data collection.

- Participant Feedback

- o Medicaid will continue to use modified participant experience measures that include questions addressing setting qualities. As part of ongoing monitoring, Medicaid may choose to further modify these measures as needed in order to target any identified statewide compliance concerns. This method will reach a representative sample of DD program participants each year.

- o Feedback from participants gathered by advocacy groups and university research entities will continue to be used, as it is available. Idaho Medicaid will continue to support these external efforts as much as possible. Any participant feedback collected in this manner will be provided to Medicaid in an electronic format that allows for data compilation and analysis.

- o Expanded HCBS-Specific Participant Survey: Each year Medicaid will identify potential areas of statewide compliance concerns and develop targeted questions to gather direct feedback from participants in those areas. Medicaid will send the Expanded HCBS-Specific Participant Survey to a random sample of participants as part of its monitoring activities for the first three years of implementation and then as needed based on information received through existing QA activities.

Any provider found to be out of compliance with the setting requirements during the initial assessment or the ongoing monitoring phase will go through an established provider remediation process. This process is to be defined as part of the detailed remediation plan which will be developed in 2016. If a rule violation is identified, action will depend on the severity. Action could range from technical assistance, a corrective action plan, or termination of a provider agreement. If it is determined that a setting does not meet HCBS requirements, participants receiving services in those settings will be notified and afforded the opportunity to make an informed choice of an alternative HCBS-compliant setting. The state will ensure that critical services and supports are in place in advance of and during the transition.

2b. Plan for Completing the Assessment of All Settings for Institutional Characteristics

Idaho has completed its assessment of all settings against the first two characteristics of an institution. There are no settings where an HCBS participant lives or receives services that are located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment. Further, there are no settings on the grounds of or immediately adjacent to a public institution. Idaho will assess all settings against the third characteristic of an institution as part of its larger assessment effort in 2017. At this point in time Idaho does not intend to request the heightened scrutiny process for any HCBS setting.

2c. Tasks and Timeline for Assessment of Residential and Non-Residential Settings

The state will conduct operational readiness work prior to beginning a formal assessment of residential and non-residential settings in 2017. The table containing the state's tasks and timeline for assessment of residential and non-residential settings can be found at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=46>

2d. Tasks and Timeline for Assessment of Settings Presumed to be Institutional

The chart illustrating the tasks and timelines for assessment of settings presumed to be institutional is located at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=51>

Major steps and timeline for moving to full compliance include:

- 1) Rule changes: completed by July 2016
- 2) Provider compliance period: completed by December 31, 2017
- 3) Assessment of compliance: beginning January 2017, completed by December 31, 2017
- 4) Provider remediation period: beginning as early as January 2017, anticipated completion early 2018
- 5) Provider sanctions or disenrollment: beginning as early as April 2017, anticipated completion early 2018
- 6) Relocation of participants as needed: beginning as early as April 2017, anticipated completion March 2019
- 7) Compliance period: beginning January 2017, completed by March 2019

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/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=51>

104905-573#page=52

2e. Plan for Provider Remediation

The state has hired an HCBS Coordinator to oversee all remediation activities. Idaho will also establish an Assessment and Monitoring Oversight Committee to support provider remediation activities. Idaho intends to complete a detailed remediation plan by March 2016. Idaho will publish the final remediation plan for public comment prior to the initiation of the assessment in 2017. However, below is a description of what the state currently plans to do in order to track and report on progress towards full compliance.

Any provider, residential or non-residential, found to be out of compliance with the setting requirements during the initial assessment or the ongoing monitoring phase will go through an established provider remediation process. This process is to be defined as part of the detailed remediation plan which will be developed in 2016. If a rule violation is identified, action will depend on the severity. Action could range from technical assistance, a corrective action plan, suspending payment of claims, or termination of a provider agreement.

The state is currently developing 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. The state anticipates establishing a tiered remediation process to allow providers ample opportunity for compliance and to allow the state time to support participants who choose to consider alternative, compliant providers.

The HCBS Program Coordinator is responsible for overseeing setting compliance and remediation activities. To do that, the coordinator will combine information from all assessment and monitoring activities which include:

- Results of HCBS-specific on-site assessments
- Provider self-assessment and transition plans
- Participant feedback received via the Participant Survey and feedback gathered by advocates
- Acknowledgement of Understanding documents to be signed by providers and participants
- Compliance surveys and reviews to be conducted by quality assurance staffs
- Corrective Action Plans
- Complaints received related to HCBS setting requirements

Section 2g includes a table (link below) with the known milestones and timelines for activities to specifically address remediation.

2f. Plan for Participant Transitions

Idaho Medicaid has a high-level plan on how the state will assist participants with the transition to compliant settings. The state will develop a more detailed relocation plan by March 2016. That plan will describe how the state will deliver adequate advance notice, which entities will be involved, how beneficiaries 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. Idaho will publish the final Relocation Plan along with the provider Remediation Plan for public comment prior to the initiation of the assessment in 2017.

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. 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. If it is determined a setting does not meet HCBS setting requirements, participants will be notified in writing along with their person-centered planning teams. They will be advised that they have a minimum of six months to find alternative care or housing if desired. An updated person-centered plan will reflect whatever the participant chooses to do. They will be given information about the support available to assist them with this transition as well as alternative HCBS compliant settings. All choices will be documented in the participant's file.

2g. Tasks and Timeline for Remediation and Participant Transitions

The table containing the state's tasks and timeline for remediation and participant transitions can be found at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=55>

Section 3: 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/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=57>

Attachments

Attachment 1: Proof of Public Noticing (located at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#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/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#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/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#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/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=140>)

Attachment 5: Index of Changes (located at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=155>)

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

- Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

Division of Family and Community Services, Idaho Department of Health and Welfare
(Complete item A-2-a).

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The state has in place a memorandum of understanding between the Division of Medicaid and the Division of Family and Community Services that outlines the roles and responsibilities related to waiver operations. The MOU describes each Divisions responsibilities as follows:

Waiver Administration and Operation

Responsibilities are as follows:

Childrens developmental disability program Enrollment - Division of Medicaid
 Childrens developmental disability enrollment managed against approved limits - Division of Medicaid
 Waiver expenditures managed against approved levels - Division of Medicaid
 Level of Care Evaluation - Division of Medicaid
 Review of participant service plans - Division of FACS
 Prior authorization of children's developmental disabilities services - Division of FACS
 Utilization management - Division of FACS
 Qualified provider enrollment - Division of FACS
 Execution of Medicaid provider agreements -Division of FACS
 Establishment of a statewide rate methodology - Division of Medicaid
 Development of rules, policies, procedures and information governing the waiver program - Division of Medicaid
 Development of policies, procedures and information governing the operations of the childrens developmental disability services- Division of FACS
 Quality assurance and quality improvement activities - Division of Medicaid/Division of FACS

Waiver Assurances Responsibilities:

Waiver and State Plan Administration and Operation.

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver/state plan program by exercising oversight of the performance of waiver/state plan functions by other state and local/regional non-state agencies (if appropriate) and contracted entities. Division of Medicaid

Participant Access and Eligibility.

An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future. Division of Medicaid

The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver. Division of Medicaid

The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care. Division of Medicaid

Participant Services.

The State monitors non-licensed/non-certified providers to assure adherence to waiver/state plan requirements. Division of FACS

The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver. Division of FACS

Participant-Centered Service Planning and Delivery.

Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver/state plan services or through other means. Division of FACS

Monitors service plan development in accordance with its policies and procedures. Division of FACS

Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs. Division of FACS

Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan. Division of FACS

Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers. Division of FACS

Participant Safeguards.

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation. Division of FACS

Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. Division of Medicaid

Quality Improvement Strategy:

Both FACS and Medicaid are jointly responsible for the overall Quality Improvement Strategy (QIS) for the childrens DD program. The following describes each divisions role for the QIS:

1) Quality Assurance (QA) staff:

- a) FACS designates staff to perform QA activities.
- b) QA staff are located across seven regions of Idaho and are responsible for collecting and reporting data to the central office Quality Management (QM) data analyst.
- c) QA staff are responsible for gathering children outcome review results, investigating complaint and critical incident reports, reviewing assessments and service plans, and submitting this information to the QM data analyst.

2) Quality Management (QM) Data Analyst:

- a) FACS acts as the QM data analyst for the childrens DD program.
- b) The QM data analyst is identified as the specialist and lead for statewide data collection activities, analysis, and reporting activities related to quality management for the childrens DD program.
- c) The QM data analyst is responsible for creating and implementing data collection tools in order to review, analyze and tabulate participant outcome review results, complaints and critical incidents, provider reviews, and plan of service information.
- d) The QM data analyst presents the data findings to the QM Manager and QM Committee for review and prioritization.

3) Quality Management (QM) Manager:

- a) Medicaid acts as the QM manager for the childrens DD program.
- b) The QM manager collaborates with the FACS policy program manager to lead team members and the QM committee, finalize quarterly and yearly QM reports, lead the process of prioritizing needs for system improvements, and implement approved system improvements.
- c) The QM manager works in collaboration with the QM data analyst to finalize quarterly and yearly QM reports.
- d) Overall data findings and recommendations are reviewed by the QM Manager prior to finalization. The quarterly progress and annual reports are reported to administration.

4) Quality Management (QM) Committee:

- a) At a minimum, the QM committee includes representation from:
 - i. Medicaid QM manager and Medicaid bureau chief
 - ii. FACS QM data analyst, FACS policy program manager, and FACS bureau chief
 - iii. Licensing and Certification program manager
- b) The committee leads the quality assessment and improvement process and issues related to parallel data collection. The QM Committee is responsible for formally recommending specific program improvements to Department Administration.
- c) The QM Committee meets on a quarterly basis to review the analyzed data in order to develop recommendations for program improvements, and review actions taken and progress made toward implementing previous approved system improvements.
- d) The QM committee meets annually upon completion of the annual QM report to prioritize findings and develop recommendations for specific system improvements for the coming year. This recommendation is submitted to administration for approval and assignment

When remediation is identified and cannot be agreed upon during the quarterly QA committee meetings, the Division of Medicaid's Bureau Chief and the Division of FACS Bureau Chief will present the issues to the Medicaid and FACS Administrators. If the issue still cannot be agreed upon the Administrators will present the issue to Medicaid's Deputy Director and FACS Deputy Director. If at that time there is no decision that is agreed upon the Deputy Directors will present the issue to the Director of the Department of Health and Welfare who will make the final decision.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

- 3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):
 - Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
 Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
 The Department contracts with an Independent Assessment Provider (IAP) to complete level of care determinations and assign individualized budgets.

 The Department also contracts with providers to help administer children's developmental disability case management.
 - No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Department of Health and Welfare oversees both the contract with the Independent Assessment Provider (IAP), and the contracts with selected providers of case management services.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Independent Assessment Provider (IAP) contract monitoring: IDHW conducts contract monitoring and reviews the performance of the IAP on a quarterly basis.

Data collection and review: Data is collected monthly by the Department's contract monitor from the contractor that reflects the contractor's performance according to the defined business model timeframes. When performance measures are not met, or there are changes in performance expectations, the Department and the contracted entity discuss the issues and identify changes as needed to resolve issues. For continued/severe issues of noncompliance, the Department may require the Contractor to submit a written corrective action plan to the Contract Monitor for review and acceptance within two (2) business days of written notification that an issue has been identified. A written corrective action plan shall identify how the issue(s) will be resolved and include timelines for resolution. The Department has ongoing access to the data, and reviews it on a quarterly basis or more often if areas of concern are identified.

Quarterly contract monitoring reports: These reports are gathered by the Department contract monitor from the contractor to look at each performance metric. To provide information in relation to compliance, the contract monitor must evaluate timeframe compliance and level of care eligibility accuracy according to the Department's business model; additionally the staff training provided during the quarter is reviewed. Any complaints and resolutions that come up are tracked on an ongoing basis, and included in the contract monitoring report. If the performance was not satisfactory, follow-up is completed by the Department contract monitor, with a request for a formal written corrective-action plan that must be submitted to the contract monitor within two (2) business days of written notification specific to the problem area.

The contractor's record review assesses files to validate that documents are tracked and accessible; necessary signatures are obtained; documents are processed within business model timeframes; accurate documentation related to participant's diagnosis, medical history and medical or behavioral needs are recorded; level of care eligibility is correctly determined according to the Idaho standard; and demographic information is correctly recorded.

Childrens Services Outcome Review (CSOR): The intent of the CSOR is to ensure that the components of the business model are implemented consistently across the state and participants are receiving services that meet their needs. This CSOR is a tool for quality review and improvement which focuses on collecting information directly from the participant and their caregivers, as well as reviewing contractor files to ensure accuracy of records. The CSOR is completed at least every year on a statistically valid sample of participants. The information received through this review process validates the performance of the contractor in relation to clinical decision making. This information is provided to the IAP contractor and a plan of correction must be developed and submitted within two (2) business days of written notification for those areas not meeting contract performance standards. The CSOR is completed by Quality Assurance (QA) staff with the Division of Family and Community Services (FACS).

The CSOR is one review consisting of three distinct sections:

Child File review: The child's file is reviewed to assess and determine if the timeframes for plan assessment, development, review and monitoring are met. Utilization is reviewed

Parent Satisfaction: Parents are contacted to assess the services their child receives. The questions address satisfaction with case management, independent assessment and service providers as well as knowledge of the services, systems available and safety reporting procedures. Parent report can trigger follow-up with the case manager or providers to assure the child's needs are met.

Observation: Observation of services are completed to determine if the services delivered by the providers meet the child's need, and are consistent to the service type, scope, amount, duration, and frequency approved within the service plan. If items are identified as deficient during the reviews, an Enhanced review will be conducted.

Collecting information from participants and caregivers validates that participants are correctly determined eligible for waiver programs; participant and guardian are satisfied with services; services continue to be clinically necessary; services accurately reflect the assessed need of the participant; identified services constitute appropriate care and warrant continued authorization; statewide consistent service delivery; statewide consistent process delivery; and compliance with the regulations governing the children's DD waiver program.

Case Management contract monitoring. Contract monitoring reviews the performance of the case management providers.

Data collection and review: Data is collected by the contract monitor on a monthly basis. The data reflects the contractor's performance outlined in their contract and according to the defined business model timeframes. When performance measures are not met, or there are changes in performance expectations, program managers from the Department and the contracted entity discuss the issues and identify changes as needed to resolve issues. The Department has ongoing access and reviews this data on a monthly basis.

Quarterly contract monitoring reports: These reports are completed by the contract monitor every 90 days following the first date of the contract. These reports look at each performance metric and provide information in relation to compliance; they evaluate timeframe compliance and plan of service accuracy according to the Department's business model. Any complaints and resolutions that come up are tracked on an ongoing basis. If the performance was not satisfactory, the contractor must submit a corrective action plan that meets department approval within five (5) business days of written notification that an issue has been identified.

Children's Services Outcome Review (CSOR): The intent of the CSOR is to ensure that the components of the business model are implemented consistently across the state and participants are receiving services that meet their needs. This CSOR is a tool for quality review and improvement which focuses on collecting information directly from the participant and their caregivers, as well as reviewing contractor files to ensure accuracy of records. The CSOR is completed at least every year on a statistically valid sample of participants. The information received through this review process validates the performance of the contractor in relation to clinical decision making. This information is provided to the case management contractor and a plan of correction must be developed and submitted within five (5) business days of written notification for those areas not meeting contract performance standards.

The CSOR is completed by Quality Assurance (QA) staff with the Division of Family and Community Services (FACS). The CSOR is one review consisting of three distinct sections:

Child File review: The child's file is reviewed to assess and determine if the timeframes for plan assessment, development, review and monitoring are met. Utilization is reviewed

Parent Satisfaction: Parents are contacted to assess the services their child receives. The questions address satisfaction with case management, independent assessment and service providers as well as knowledge of the services, systems available and safety reporting procedures. Parent report can trigger follow-up with the case manager or providers to assure the child's needs are met.

Observation: Observation of services are completed to determine if the services delivered by the providers meet the child's needs, and are consistent to the service type, scope, amount, duration, and frequency approved within the service plan. If items are identified as deficient during the reviews, an Enhanced review will be conducted.

Collecting information from participants and caregivers validates that participants are correctly determined eligible for waiver programs; participant and guardian satisfaction with services; services continue to be clinically necessary; services accurately reflect the assessed need of the participant; identified services constitute appropriate care and warrant continued authorization; statewide consistent service delivery; statewide consistent process delivery; and compliance with the regulations governing the children's DD waiver program.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of remediation issues identified by contract monitoring reports that were addressed by the state. a. Numerator: Number of identified remediation issues addressed by the state b. Denominator: Number of remediation issues identified by contract monitoring reports.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Department monitors contractors for timeliness and accuracy of DD and waiver eligibility determinations and contracted Case Management responsibilities through a combination of concurrent, retrospective reviews; reconsideration of decision data; and quality assurance data provided quarterly to the Department's IAP contract monitor and the Department's Case Management contract monitor.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Non-compliance will result in the contractor developing and submitting a plan of correction within five (5) business days for the case management contractor and within two (2) business days for the IAP for Department approval. Continued non-compliance may result in termination of the contract.

The QM Committee meets on a quarterly basis to review the performance reports, remediation and develop recommendations for system improvements, and review actions taken and progress made toward implementing previous approved system improvements. The contract monitor will document actions taken and progress made. Data will be submitted to the QA manager for review at the QM meeting and recorded in the quarterly and annual reports.

If remediation is identified and cannot be agreed upon during the quarterly QA committee meetings, the Division of Medicaid's Bureau Chief and the Division of FACS Bureau Chief will present the issues to the Medicaid and FACS Administrators. If the issue still cannot be agreed upon the Administrators will present the issue to Medicaid's Deputy Director and FACS Deputy Director. If at that time there is no decision that is agreed upon the Deputy Directors will present the issue to the Director of the Department of Health and Welfare who will make the final decision.

- ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input checked="" type="checkbox"/>	Autism	<input type="text" value="0"/>	<input type="text" value="17"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	<input type="text" value="0"/>	<input type="text" value="17"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Intellectual Disability	<input type="text" value="0"/>	<input type="text" value="17"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	

	<input type="checkbox"/>	Serious Emotional Disturbance			
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b. **Additional Criteria.** The State further specifies its target group(s) as follows:

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Within 6-9 months of the participant's 18th birthday, participants who want to apply for Adult DD Waiver services can apply through the Bureau of Developmental Disability Services located at their local Medicaid office. However, Adult developmental disability (DD) Waiver services cannot begin before the participant's 18th birthday.

The child's plan developer completes all duties identified on the Care Manager Adult Intake Checklist, and then forwards the Eligibility Application for Adults with DD and any other intake documents to the Adult program's Independent Assessment Provider (IAP).

For applications received within 6 to 9 months of a participant turning 18, the IAP can begin the assessment process and determine Adult DD Waiver eligibility prior to the participant's 18th birthday. Documentation of the participant's developmental disability prior to age 22 should be made available to the IAP. This includes previous psychological and/or medical records.

The IAP will review the application and schedule an intake appointment with the participant to complete the DD and ICF/ID Level of Care (LOC) eligibility process. The participant must attend the intake appointment with their parent/legal guardian. The parent/legal guardian will serve as the respondent for the Scales of Independent Behavior Revised (SIBR).

The participant will receive notices from the IAP indicating whether their Adult DD Waiver eligibility has been approved or denied. A copy of the eligibility determination and available assessments will be shared with the child's assigned case manager.

If the participant is not determined Adult DD Waiver eligible, a Notice of Decision will inform the participant of the denial and their right to appeal. The assigned case manager can assist the participant in accessing other available services and resources to meet their needs.

If the participant is determined Adult DD Waiver eligible, the Notice of Decision will notify the participant of their approval and calculated individualized budget. The notice will provide them with information about the option to choose either the Traditional Option or the Self-Directed Option. The participant's current case manager will identify tasks associated with transitioning the participant into the Adult DD Program. Children's case management services will end effective the start date identified on the participant's approved and prior authorized adult plan.

If the participant chooses the Self-Direction Option, they will need to contact the Bureau of Developmental Disability Services to follow the processes associated with that choice.

If the participant chooses the Traditional Option, they will decide which Service Coordination agency they would like to provide plan development. The participant must notify the IAP of their choice.

NOTE: Plan development can be approved but cannot be prior authorized until the participant has turned 18. The

plan developer must submit a written request to the Department for plan development hours. This request will be reviewed and approved by the assigned adult care manager. The development of an adult DD service plan will help guide service provision to the participant through the next year.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

- a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:
- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
 - Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- A level higher than 100% of the institutional average.**

Specify the percentage:

- Other**

Specify:

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is (*select one*):

- The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

- Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
- The following percentage that is less than 100% of the institutional average:

Specify percent:

- Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- The participant is referred to another waiver that can accommodate the individual's needs.
- Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated

participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2277
Year 2	2329
Year 3	2380
Year 4	2432
Year 5	2483

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (*select one*):

- The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

- Not applicable. The state does not reserve capacity.**
- The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- The waiver is not subject to a phase-in or a phase-out schedule.**
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the**

waiver.

e. Allocation of Waiver Capacity.

Select one:

- Waiver capacity is allocated/managed on a statewide basis.**
- Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Age birth up to the child's 18th birthday. The participant must meet ICF/ID level of care. Income at or less than 300% of SSI Federal Benefit Rate. Entry to the waiver is offered to individuals based on the date of their application for the waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. State Classification. The State is a (*select one*):

- §1634 State
- SSI Criteria State
- 209(b) State

2. Miller Trust State.

Indicate whether the State is a Miller Trust State (*select one*):

- No
- Yes

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- Low income families with children as provided in §1931 of the Act
- SSI recipients
- Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- Optional State supplement recipients
- Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)
- % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act
- Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Special home and community-based waiver group under 42 CFR §435.217 Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
- Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

- A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

- 100% of FPL
- % of FPL, which is lower than 100%.

Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (select one):

- Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals**

with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant *(select one)*:

- The following standard included under the State plan

Select one:

- SSI standard
 Optional State supplement standard
 Medically needy income standard
 The special income level for institutionalized persons

(select one):

- 300% of the SSI Federal Benefit Rate (FBR)
 A percentage of the FBR, which is less than 300%

Specify the percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

- The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:

Specify:

300% of the SSI Federal Benefit Rate plus the following personal needs allowances if there is enough income.

Persons with earned income. The personal needs allowance is increased by \$200 or the amount of their earned income, whichever is less. These individuals need a greater personal needs allowance to offset their costs incurred in earning income.

Persons with a court-ordered guardian. The personal needs allowance is increased by guardianship fees not to exceed 10% of the monthly benefit handled by the guardian, or \$25, whichever is less. Where the guardian and the trustee are the same individual, the total deduction for guardian and trust fees must not exceed \$25. The individual needs a greater personal needs allowance to offset their guardian fees.

Persons with a trust. The personal needs allowance is increased by trust fees, not to exceed \$25 paid to the trustee for administering the individual's trust. These individuals need a greater personal needs allowance to offset their trust fees.

Blind or disabled employed persons with impairment-related work expenses. Impairment-related work expenses are purchased or rented items and services purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment related items is deducted. Expenses must not be averaged. These individuals need a greater personal needs allowance to offset their impairment-related work expenses.

Other

Specify:

ii. Allowance for the spouse only (select one):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

- Not Applicable (see instructions)
- AFDC need standard
- Medically needy income standard
- The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- The amount is determined using the following formula:

Specify:

- Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions) *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.
- The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

- c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this

section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons
- A percentage of the Federal poverty level

Specify percentage:

- The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

- The following formula is used to determine the needs allowance:

Specify formula:

300% of the SSI Federal Benefit Rate plus the following personal needs allowances if there is enough income.

Persons with earned income. The personal needs allowance is increased by \$200 or the amount of their earned income, whichever is less. These individuals need a greater personal needs allowance to offset their costs incurred in earning income.

Persons with a court-ordered guardian. The personal needs allowance is increased by guardianship fees not to exceed 10% of the monthly benefit handled by the guardian, or \$25, whichever is less. Where the guardian and the trustee are the same individual, the total deduction for guardian and trust fees must not exceed \$25. The individual needs a greater personal needs allowance to offset their guardian fees.

Persons with a Trust. The personal needs allowance is increased by trust fees, not to exceed \$25 paid to trustee for administering the individual's trust. These individuals need a greater personal needs allowance to offset their trust fees.

Blind or disabled employed persons with impairment -related work expenses. Impairment-related work expenses are purchased or rented items and services purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment related items is deducted. Expenses must not be averaged. These individuals need a greater personal needs allowance to offset their impairment-related work expenses.

Other

Specify:

ii. **If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

iii. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

The State does not establish reasonable limits.

The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. **Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.**

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. **Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this

section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

- ii. Frequency of services.** The State requires (select one):

- The provision of waiver services at least monthly**
 Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (select one):

- Directly by the Medicaid agency**
 By the operating agency specified in Appendix A
 By an entity under contract with the Medicaid agency.

Specify the entity:

The Independent Assessment Provider (IAP)

- Other**
Specify:

- c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Qualified Intellectual Disabilities Professional (QIDP).

A QIDP has at least one (1) year of experience working directly with persons with intellectual disabilities or other developmental disabilities and is licensed as a doctor of medicine or osteopathy, or as a registered nurse, or has at least a bachelor's degree in one (1) of the following professional categories; psychology, social work, occupational therapy, speech pathology, audiology, professional recreation, or a related human services profession.

- d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

All participants must meet ICF/ID Level of Care (LOC). ICF/ID LOC is defined in Idaho Administrative Rule at IDAPA 16.03.10.584, and requires the participant have a developmental disability as defined in Section 66-402, Idaho Code and in Sections 500 through 503 of IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." Developmental disability means a chronic disability of a person which appears before the age of twenty-two (22) years of age and:

- (a) Is attributable to an impairment, such as intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; and
(b) Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and
(c) Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated.

The Scales of Independent Behavior - Revised (SIB-R) is used to evaluate functional limitations and maladaptive behavior. The IAP will conduct an assessment within thirty (30) days of receiving a complete application or annual questionnaire from the family.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
 A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The Independent Assessment Provider (IAP) collects evaluations and other information relevant to the participant's developmental disability. Typically, these evaluations include IQ testing or medical assessments/diagnoses to document that the participant meets categorical impairment criteria outlined in Section 66-402, Idaho Code. In

addition, the IAP conducts the SIB-R assessment and completes the Medical/Social and Developmental History to make a final eligibility determination for developmental disability services as outlined in Sections 500 through 503 of IDAPA 16.03.10 and ICF/ID Level of Care (LOC) criteria as outlined in Section 584 of IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits."

All LOC decisions are forwarded to the Department's case managers and contractors electronically, as well as maintained in the participant files located at the IAP offices. Participants receive written notification regarding their LOC determinations. Participants who are found to not meet LOC criteria are informed of their right to request an appeal.

The annual reevaluation is the same as above except the IAP may not always conduct a new SIB-R if the clinical review indicates the previous assessment is still reflective of the participant's current condition. The annual clinical review includes a review of the participant's current status and evaluation for substantial change.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- Every three months
- Every six months
- Every twelve months
- Other schedule

Specify the other schedule:

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.

Specify the qualifications:

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

The Independent Assessment Provider (IAP) utilizes an electronic database to track annual redetermination dates and ensure timely reevaluations. The Department ensures the IAP continues to meet the contract timeframe requirements for evaluations through monitoring of quarterly IAP reports and annual statewide reviews.

The IAP is required to check the database at least on a monthly basis to identify the children who have 4 months before the ending of the child's current Plan of Service.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The IAP maintains these records at their regional hub offices.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

- a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. *Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of applicants for HCB services who received an eligibility assessment. a. Numerator: Number of applicants for HCB services who received an eligibility assessment. b. Denominator: Number of applicants for HCB services

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. **Sub-assurance:** *The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. **Sub-assurance:** *The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of eligibility determinations made according to policy a.
Numerator: Number of eligibility determinations that were determined according to policy b. Denominator: Number of eligibility determinations

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% and a confidence level of 95%.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually

<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Department monitors contractors for timeliness and accuracy of DD and waiver eligibility determinations through a combination of concurrent, retrospective reviews; reconsideration of decision data; and quality assurance data provided quarterly by the Department's IAP contract monitor.

The QM Committee meets on a quarterly basis to review remediation and develop recommendations for system improvements.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Non-compliance will result in the contractor developing and submitting a plan of correction within two (2) business days of written notification that an issue has been identified. Continued non-compliance may result in termination of the contract.

The Contract Monitor will increase monitoring in situations where remediation was required by the Department. Within 30 days of receiving an accepted Plan of Correction from the contractor, the contract monitor will do the following: Phone calls to participants and/or the contractor; increased file reviews; and eligibility database reviews to ensure that the proper changes and/or remediation activities were completed and intended outcomes achieved.

The QM Committee meets on a quarterly basis, (every 90 days) to review the remediation and develop recommendations for system improvements, and review actions taken and progress made toward implementing previous approved system improvements. The QA Manager will document actions taken and progress made in the quarterly and annual reports.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Continuously and Ongoing	
<input type="checkbox"/> Other Specify: <input type="text"/>	

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

At the time of waiver application, the IAP provides participants with information about waiver services. When a participant is determined eligible for waiver services, the assigned case manager provides additional information about available services. Eligible participants and their family-centered planning teams select the specific waiver services they wish to receive by including these services on the plan of service. In addition, this plan includes a statement that the participant chooses to receive HCBS waiver services in the community rather than services in an ICF/ID.

- b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The plan of service which documents freedom of choice is maintained in the following locations:

The Independent Assessment Provider's office through their defined database.
 The assigned case manager's office through a Department database (Therap!)
 The participant's file.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The Department makes many of its publications available in both English and Spanish. These publications are displayed and distributed in the regional offices throughout the state. An example of one of these publications, the "Idaho Health Plan Coverage" booklet, is also available online. It provides an overview of Medicaid services in Idaho including waiver services. It can be accessed at <http://healthandwelfare.idaho.gov/Medical/tabid/61/Default.aspx>.

In addition, the State of Idaho website has been translated into Spanish at <http://idaho.gov/espanol.html> and has a link to the Department of Health & Welfare website in Spanish. The main Department of Health and Welfare website at www.healthandwelfare.idaho.gov also provides a link to a Spanish version by clicking the "Español" button at the top of the page. Individuals who have additional questions are directed on these websites to contact the widely-publicized Idaho Care

Line by dialing 2-1-1.

The Department’s Division of Human Resources maintains a list of Department staff available for translation assistance for various languages. This information is located on the Department’s Infonet and is divided by region. It also lists people who are not employed by the Department that have made themselves available to provide translation services.

Information on using Language Line Services is also included. The Department has a contract with this entity to provide translation for various languages via the telephone.

Translation services are provided free of charge to the families.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Extended State Plan Service	Family Education		
Extended State Plan Service	Habilitative Supports		
Extended State Plan Service	Respite		
Supports for Participant Direction	Community Support Services		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Support Broker Services		
Other Service	Crisis Intervention		
Other Service	Family Training		
Other Service	Habilitative Intervention		
Other Service	Interdisciplinary Training		
Other Service	Therapeutic Consultation		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service ▼

Service Title:

Family Education

HCBS Taxonomy:

Category 1:

Sub-Category 1:

08 Home-Based Services

08010 home-based habilitation ▼

Category 2:

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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

- Family education may also provide assistance to the parent or legal guardian in educating other unpaid caregivers regarding the needs of the participant.
- The family education providers must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service.
- Family education may be provided in a group setting not to exceed five (5) participants' families.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services are provided when the limits of family education under the approved 1915i HCBS State plan option are exhausted. The scope and nature of these services do not otherwise differ from family education services furnished under the 1915i State plan. The additional amount of services beyond the budget limitation defined for 1915i services that may be provided are subject to the participant's individual budget as defined in C-4 of the waiver.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Developmental Disabilities Agency
Agency	Early Intervention

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Family Education

Provider Category:

Provider Type:

Developmental Disabilities Agency

Provider Qualifications

License (specify):

Certificate (specify):

Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.

Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410 which include:

- Yearly Training, minimum of twelve (12) hours of formal training each calendar year that include:
- Fire and safety training
- CPR and first aid

The following trainings are included in training requirements as applicable to their work assignments and responsibilities:

- Training to meet any special health or medical requirements of the participants they serve
- Optimal independence
- assistive technology used by participants
- Accurate record keeping and data collection procedures
- Adequate observation, review, and monitoring of staff, volunteer, and participant performance to promote the achievement of participant goals and objectives
- Participant's rights, advocacy resources, confidentiality, safety, and welfare; and
- Proper implementation of all policies and procedures developed by the agency

Additional Training for Professionals. Training of all professional staff must include the following as applicable to their work assignments and responsibilities:

- a. Correct and consistent implementation of all participants' individual program plans and implementation plans, to achieve individual objectives;
- b. Consistent use of behavioral and developmental programming principles and the use of positive behavioral intervention techniques.

In addition must meet the following qualifications to provide family education in a DDA:

- Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college, and has:
- One (1) year experience providing care to children with developmental disabilities;
- Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide family education;
- Must satisfactorily complete a criminal history and background check

When services are provide to children birth - 3 staff are required to have the following:

- Minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following:
 - An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or
 - A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or
 - A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing
 - plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content:
 - o Promotion of development and learning for children from birth to three (3) years;
 - o Assessment and observation methods for developmentally appropriate assessment of young children;
 - o Building family and community relationships to support early interventions;
 - o Development of appropriate curriculum for young children, including IFSP and IEP development;
 - o Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and
 - o Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development.
 - o Electives closely related to the content under Subsection 665.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education.
 - o Developmental specialists who possess a bachelor's or master's degree listed above, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- A review within 6 months of providing services
- At least every 3 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Family Education

Provider Category:

Agency 

Provider Type:

Early Intervention

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410 which includes:

- Yearly Training, minimum of twelve (12) hours of formal training each calendar year that include:
- Fire and safety training
- CPR and first aid

The following trainings are included in training requirements as applicable to their work assignments and responsibilities:

- Training to meet any special health or medical requirements of the participants they serve
- Optimal independence
- assistive technology used by participants
- Accurate record keeping and data collection procedures
- Adequate observation, review, and monitoring of staff, volunteer, and participant performance to promote the achievement of participant goals and objectives
- Participant's rights, advocacy resources, confidentiality, safety, and welfare; and
- Proper implementation of all policies and procedures developed by the agency

Additional Training for Professionals. Training of all professional staff must include the following as applicable to their work assignments and responsibilities:

- a. Correct and consistent implementation of all participants' individual program plans and implementation plans, to achieve individual objectives;
- b. Consistent use of behavioral and developmental programming principles and the use of positive behavioral intervention techniques.

In addition must meet the following qualifications to provide family education:

- Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college, and has:
- One (1) year experience providing care to children with developmental disabilities;
- Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide family education;
- Must satisfactorily complete a criminal history and background check
- Minimum of two hundred forty (240) hours of professionally-supervised experience with young

children who have developmental disabilities and one (1) of the following:

- An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or
- A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or
- A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing
- plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content:
 - o Promotion of development and learning for children from birth to three (3) years;
 - o Assessment and observation methods for developmentally appropriate assessment of young children;

- o Building family and community relationships to support early interventions;
- o Development of appropriate curriculum for young children, including IFSP and IEP development;
- o Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and
- o Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development.
- o Electives closely related to the content under Subsection 665.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education.
- o Developmental specialists who possess a bachelor's or master's degree listed above, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement.

- When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area:

The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- Within 6 months of providing services to participants
- At least every 2 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service ▼

Service Title:

Habilitative Supports

HCBS Taxonomy:

Category 1:

Sub-Category 1:

08 Home-Based Services

08010 home-based habilitation ▼

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Habilitative Supports provides assistance to a participant with a disability by facilitating the participant’s independence and integration into the community. This service provides an opportunity for participants to explore their interests, practice skills learned in other therapeutic environments, and learn through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory motor, communication, socialization, personal care, relationship building, and participation in leisure and community activities. Habilitative Supports must:

- Not supplant services provided in school or therapy, or supplant the role of the primary caregiver;
- Ensure the participant is involved in age-appropriate activities and is engaging with typical peers according to the ability of the participant

The supports provider must maintain a log of the habilitative support services in the participant’s record documenting the provision of activities outlined in the plan of service.

Limitations:

- Habilitative Supports cannot be provided during the same time other waiver services are being provided to a participant.
- Habilitative Supports shall not duplicate other Medicaid reimbursed services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services are provided when the limits of habilitative supports under the approved 1915i HCBS State plan option are exhausted. The scope and nature of these services do not otherwise differ from habilitative support services furnished under the 1915i State plan. The additional amount of services beyond the budget limitation defined for 1915i services that may be provided are subject to the participant's individual budget as defined in C-4 of the waiver.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Early Intervention
Agency	Developmental Disabilities Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Habilitative Supports

Provider Category:Agency **Provider Type:**

Early Intervention

Provider Qualifications**License (specify):**


Certificate (specify):


Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410 which include:

- Yearly Training, minimum of twelve (12) hours of formal training each calendar year that include:
- Fire and safety training
- CPR and first aid

The following trainings are included in training requirements as applicable to their work assignments and responsibilities:

- Training to meet any special health or medical requirements of the participants they serve
- Optimal independence
- assistive technology used by participants
- Accurate record keeping and data collection procedures
- Adequate observation, review, and monitoring of staff, volunteer, and participant performance to promote the achievement of participant goals and objectives
- Participant's rights, advocacy resources, confidentiality, safety, and welfare; and
- Proper implementation of all policies and procedures developed by the agency

In addition must meet the following qualifications to provide habilitative supports:

- Must be at least eighteen (18) years of age;
- Must be a high school graduate or have a GED;
- Have received instructions in the needs of the participant who will be provided the service;
- Demonstrate the ability to provide services according to a plan of service;
- Must have six (6) months supervised experience working with children with developmental disabilities.
- Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative supports.
- Must satisfactorily complete a criminal history background check
- Have transcribed courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education, or closely-related coursework; or
- Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist.

Verification of Provider Qualifications**Entity Responsible for Verification:**

The Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- Within 6 months of providing services to participants
- At least every 2 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C H S Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Habilitative Supports

Provider Category:

Agency ▼

Provider Type:

Developmental Disabilities Agency

Provider Qualifications

License (specify):

Certificate (specify):

Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.

Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410 which include:

- Yearly Training, minimum of twelve (12) hours of formal training each calendar year that include:
- Fire and safety training
- CPR and first aid

The following trainings are included in training requirements as applicable to their work assignments and responsibilities:

- Training to meet any special health or medical requirements of the participants they serve
- Optimal independence
- assistive technology used by participants
- Accurate record keeping and data collection procedures
- Adequate observation, review, and monitoring of staff, volunteer, and participant performance to promote the achievement of participant goals and objectives
- Participant's rights, advocacy resources, confidentiality, safety, and welfare; and
- Proper implementation of all policies and procedures developed by the agency

In addition staff must meet the following qualifications to provide habilitative supports in a DDA:

- Must be at least eighteen (18) years of age;
- Must be a high school graduate or have a GED;
- Have received instructions in the needs of the participant who will be provided the service;
- Demonstrate the ability to provide services according to a plan of service;
- Must have six (6) months supervised experience working with children with developmental disabilities.
- Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative supports.
- Must satisfactorily complete a criminal history background check

If services are provided to children birth - 3 the staff must:

- Have transcribed courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education, or closely-related coursework; or
- Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- A review within 6 months of providing services
- At least every 3 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service ▼

Service Title:

Respite

HCBS Taxonomy:

Category 1:

Sub-Category 1:

09 Caregiver Support

09012 respite, in-home ▼

Category 2:

Sub-Category 2:

09 Caregiver Support

09011 respite, out-of-home ▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

Respite provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver. Respite is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Respite may be provided in the participant's home, the private home of the respite provider, a DDA, or in the community. Payment for respite services are not made for room and board.

Limitations:

- Respite must only be offered to participants living with an unpaid caregiver who requires relief.
- Respite cannot exceed fourteen (14) consecutive days.
- Respite must not be provided at the same time other Medicaid services are being provided.
- Respite must not be provided on a continuous, long-term basis as a daily service that would enable an unpaid caregiver to work.
- Respite cannot be provided as group- or center-based respite when delivered by an independent respite provider.
- Respite services cannot duplicate other Medicaid reimbursed services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services are provided when the limits of respite under the approved 1915i HCBS State plan option are exhausted. The scope and nature of these services do not otherwise differ from respite services furnished under the 1915i State plan. The additional amount of services beyond the budget limitation defined for 1915i services that may be provided are subject to the participant's individual budget as defined in C-4 of the waiver.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Developmental Disabilities Agency
Individual	Respite Care Provider
Agency	Early Intervention

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Developmental Disabilities Agency

Provider Qualifications

License (specify):

Certificate (specify):

Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.

Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410.

In addition must meet the following qualifications to provide respite in a DDA:

- Must be at least sixteen (16) years of age when employed by a DDA;
- Meet the qualifications prescribed for the type of services to be rendered, or must be an individual selected by the participant, the family, or the participant's guardian;
- Have received instructions in the needs of the participant who will be provided the service;
- Demonstrate the ability to provide services according to a plan of service;
- Must satisfactorily complete a criminal history background check

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- A review within 6 months of providing services
- At least every 3 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Respite

Provider Category:

Individual

Provider Type:

Respite Care Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individuals must meet the following qualifications to provide respite:

- Must be at least eighteen (18) years of age and be a high school graduate, or have a GED;
- Meet the qualifications prescribed for the type of services to be rendered, or must be an individual selected by the participant, the family, or the participant’s guardian;
- Have received instructions in the needs of the participant who will be provided the service;
- Demonstrate the ability to provide services according to a plan of service;
- Must satisfactorily complete a criminal history background check
- Must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- Within 6 months of providing services to participants
- At least every 2 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Respite

Provider Category:

Provider Type:

Early Intervention

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410.

In addition must meet the following qualifications to provide respite:

- Must be at least sixteen (16) years of age when employed by a DDA;
- Meet the qualifications prescribed for the type of services to be rendered, or must be an individual selected by the participant, the family, or the participant’s guardian;
- Have received instructions in the needs of the participant who will be provided the service;
- Demonstrate the ability to provide services according to a plan of service;
- Must satisfactorily complete a criminal history background check

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- Within 6 months of providing services to participants
- At least every 2 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Community Support Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

12 Services Supporting Self-Direction	12020 information and assistance in support of se
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Category 2:

Sub-Category 2:

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Category 3:

Sub-Category 3:

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Category 4:

Sub-Category 4:

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Service Definition (Scope):

Community Support Services provide goods and supports that are medically necessary and/or minimize the participant's need for institutionalization. Community Support Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that are based on the child's assessed needs that are identified in the plan of service (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the participants safety in the home environment; AND, the participant does not have the funds to purchase the item or service or the item or service is not available through another source. Community Support Services are purchased from the family-directed budget. Experimental or prohibited treatments are excluded. Community Support Services must be documented in the plan of service. Community Support Services address the participant's preferences for:

- Personal support to help the participant maintain health, safety, and basic quality of life.

- Relationship support to help the participant establish and maintain positive relationships with immediate family members, friends, or others in order to build a natural support network and community.
- Emotional support to help the participant learn and practice behaviors consistent with their goals and wishes while minimizing interfering behaviors.
- Adaptive support to help a child to learn new adaptive skills or expand their existing skills.
- Transportation support to help the participant accomplish their identified goals. This transportation is for non-medical needs.
- Adaptive equipment to address an identified medical or accessibility need in the service plan (improving and maintaining the participant’s opportunities for full membership in the community) and meet the following requirements:
 - A safe and effective treatment that meets acceptable standards of medical practice
 - Items needed to optimize the health, safety and welfare of the participant
 - The least costly alternative that reasonably meets the participant’s need
 - For the sole benefit of the participant
 - The participant does not have the funds to purchase the item or the item is not available through another source.

Adaptive and therapeutic equipment must also meet at least one of the following:

- maintain the ability of the participant to remain in the community,
- enhance community inclusion and family involvement,
- decrease dependency on formal support services and thus increase independence of the participant OR
- provide unpaid family members and friends training in the use of the equipment to provide support to the participant.

Adaptive and therapeutic equipment are not otherwise covered under Durable Medical Equipment (DME). Services and equipment that are available through the Medicaid State plan as 1905(a) services for children per Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements are not allowed as payable under family-directed community support services. Experimental or prohibited treatments are excluded.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only participants who select the Family-Directed Option may access this service. There are no limits on the amount, frequency, or duration of these services other than participants must stay within their individual budget amount defined in C-4.

When services are offered through the state plan, the child will have access to these services. If additional services are identified a child can request early periodic screening, diagnosis and treatment (EPSDT) Services. State plan services and EPSDT services will not be counted against the child’s budget. Support brokers are trained on state plan services and EPSDT services and will assist the family to access these services.

Service Delivery Method *(check each that applies):*

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by *(check each that applies):*

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Community Support Provider
Agency	Community Support Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Community Support Services

Provider Category:

Individual ▾

Provider Type:

Community Support Provider

Provider Qualifications

License (specify):

If the provider is required in state statute to have a license to deliver the service or goods the family must assure that the Community Support Worker has a license.

Certificate (specify):

If the provider is required in state statute to have a certificate to deliver the service or goods the family must assure that the Community Support Worker has a certificate.

Other Standard (specify):

Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant and parent/legal guardian

Support Broker

Department of Health and Welfare (during retrospective quality assurance reviews)

Frequency of Verification:

Initially and annually, with review of employment/vendor agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Community Support Services

Provider Category:

Agency ▾

Provider Type:

Community Support Agency

Provider Qualifications

License (specify):

If the provider is required in state statute to have a license to deliver the service or goods the family must assure that the Community Support Worker has a license.

Certificate (specify):

If the provider is required in state statute to have a certificate to deliver the service or goods the family must assure that the Community Support Worker has a certificate.

Other Standard (specify):

Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant and parent/legal guardian

Support Broker

Department of Health and Welfare (during retrospective quality assurance reviews)

Frequency of Verification:

Initially and annually, with review of employment/vendor agreement

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction ▼

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services ▼

Alternate Service Title (if any):

Financial Management Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

12 Services Supporting Self-Direction 12010 financial management services in support of

Category 2:

Sub-Category 2:

▼

Category 3:

Sub-Category 3:

▼

Category 4:

Sub-Category 4:

▼

Service Definition (Scope):

The Department will offer financial management services provided by any qualified fiscal employer/agent (F/EA) provider through a provider agreement.

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

- A. Payroll and Accounting. Providing payroll and accounting supports to participants that have chosen the family-directed community supports option;
- B. Financial Reporting. Performing financial reporting for employees of each participant;
- C. Financial Information Packet. Preparing and distributing a packet of information, including department approved forms for agreements, for the participant and family hiring their own staff;
- D. Time Sheets and Invoices. Processing and paying timesheets for community support workers and support brokers, as authorized by the participant and family according to the participant's Department authorized support and spending plan;
- E. Taxes. Managing and processing payment of required state and federal employment taxes for the participant's community support worker and support broker;
- F. Payments for goods and services. Processing and paying invoices for goods and services, as authorized by the participant and family, according to the participant's support and spending plan;
- G. Spending information. Providing each participant and family with reporting information and data that will assist the participant with managing the individual budget;

H. Quality assurance and improvement. Participation in Department quality assurance activities, including reporting.

FE/A providers complete financial services and financial consultation for participants and their parent/legal guardian that is related to a family-directed participant's individual budget. The F/EA assures that the financial data related to the participant's budget is accurate and available to them and their parent/legal guardian as necessary in order for successful family-direction to occur. F/EA qualifications and requirements and responsibilities as well as allowable activities are described in Idaho Administrative Rules 16.03.13.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

The F/EA providers may only provide financial consultation, financial information and financial data to the participant and their parent/legal guardian, and may not provide counseling or information to the participant and parent/legal guardian about other goods and services. The F/EA will complete reporting activities identified by the Department under quality assurance and improvement requirements.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Fiscal Employer/Agent (F/EA)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Fiscal Employer/Agent (F/EA)

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Agencies that provide financial management services as a F/EA must be qualified to provide such services as indicated in section 3504 of the Internal Revenue Code. Agencies must also be in compliance with Idaho Administrative rules: 16.03.13 "Consumer-Directed Services"

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- Within 6 months of providing services to participants
- At least every 2 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction ▼

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction ▼

Alternate Service Title (if any):

Support Broker Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

12 Services Supporting Self-Direction	12020 information and assistance in support of se
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Category 2:

Sub-Category 2:

	▼
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Category 3:

Sub-Category 3:

	▼
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Category 4:

Sub-Category 4:

	▼
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Service Definition (Scope):

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

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

- Participate in the person centered planning process.

- Develop a written support and spending plan with the participant and family that includes the supports the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes backup plans should a support fall out.
- Assist the participant and family to monitor and review their budget through data and financial information provided by the F/EA.
- Submit documentation regarding the participant and family's satisfaction with identified supports as requested by the Department.
- Participate with Department quality assurance measures, as requested.
- Assist the participant and family with scheduling required assessments to complete the Department's annual re-determination process as needed, including assisting the participant and family to update the support and spending plan and submit it to the Department for authorization in a timely manner.

In addition to the required minimum support broker duties, the support broker must be able to provide the following services when requested by the participant and family:

- Assist the participant and family to develop and maintain a circle of support.
- Help the participant and family learn and implement the skills needed to recruit, hire, and monitor community supports.
- Assist the participant and family to negotiate rates for paid Community Support Workers.
- Maintain documentation of supports provided by each Community Support Worker and participant's satisfaction with these supports.
- Assist the participant and family to monitor community supports.
- Assist the participant and family to resolve employment-related problems.
- Assist the participant and family to identify and develop community resources to meet specific needs.

Support Brokers provide counseling and assistance for families by arranging, directing and managing services. This includes providing families with any assistance they need for gathering and reviewing their budget and financial data and reports prepared and issued to them by the F/EA. Support Broker qualifications, requirements and responsibilities as well as allowable activities are described in Idaho Administrative Rules in IDAPA 16.03.13.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only participants who select the Family-Directed Option may access this service.

Support brokers may not act as a fiscal employer agent; instead support brokers work together with the participant and family to review participant financial information that is produced and maintained by the fiscal employer agent (F/EA).

There are no limits on the amount, frequency, or duration of these services other than participants must stay within their individual budget amount defined in C-4.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person**

- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Support Broker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Support Broker Services

Provider Category:

Individual ▾

Provider Type:

Support Broker

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Specific requirements outlined in Idaho Administrative Code - IDAPA 16.03.13 which includes:

- Criminal history check
- Is eighteen (18) years of age or older;
- Has 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
- Has at least two (2) years verifiable experience with the target population and knowledge of services and resources in the developmental disabilities field.
- Attend the initial training and pass the application exam
- Required Ongoing Training. All support brokers must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of support broker services. Up to six (6) hours of the required twelve (12) hours may be obtained through independent self-study. The remaining hours must consist of classroom training.

The parent/legal guardian can be an unpaid support broker for the participant and are subject to the same qualification requirements as paid support brokers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Participant and Parent/legal guardian
 Department of Health and Welfare

Frequency of Verification:

At the time of application, annual review of ongoing education requirement, and by participant when entering into employment agreement.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request

through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Crisis Intervention

HCBS Taxonomy:

Category 1:

Sub-Category 1:

10 Other Mental Health and Behavioral Services	10030 crisis intervention
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Category 2:

Sub-Category 2:

	▼
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Category 3:

Sub-Category 3:

	▼
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Category 4:

Sub-Category 4:

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Service Definition (Scope):

Crisis intervention services provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant, and also provides emergency back-up involving the direct support of the participant in crisis. Children's crisis intervention services may be provided in the home and community.

- Crisis services must use positive behavior interventions prior to and in conjunction with the implementation of any restrictive intervention.
- If staying in the home endangers the health and safety of the participant or family, the provider may request short-term out of home placement for the participant. Out of home placement must be prior authorized by the Department.
- Crisis intervention services will not duplicate other Medicaid reimbursed services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Department authorization is required.

Crisis is provided on a short-term basis typically not to exceed thirty (30) days, and cannot exceed fourteen (14) days of out-of-home placement.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title

Agency	Developmental Disabilities Agency Provider
Agency	Early Intervention
Individual	Independent Crisis Intervention Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Crisis Intervention

Provider Category:

Agency ▼

Provider Type:

Developmental Disabilities Agency Provider

Provider Qualifications

License (specify):

Certificate (specify):

- Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.

Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410.

In addition must meet the following qualifications to provide crisis intervention in a DDA:

- Crisis professionals must meet the minimum provider qualifications under therapeutic consultation services.
- This service also provides for emergency technician services for direct support of a recipient in crisis in addition to the primary care giver. Emergency intervention technician must meet the minimum provider qualifications under Habilitative Support services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- A review within 6 months of providing services
- At least every 3 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Crisis Intervention

Provider Category:

Agency ▼

Provider Type:

Early Intervention

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410.

In addition must meet the following qualifications to provide crisis intervention:

- Crisis professionals must meet the minimum provider qualifications under therapeutic consultation services.
- This service also provides for emergency technician services for direct support of a recipient in crisis in addition to the primary care giver. Emergency intervention technician must meet the minimum provider qualifications under Habilitative Support services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- Within 6 months of providing services to participants
- At least every 2 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Crisis Intervention

Provider Category:

Individual ▾

Provider Type:

Independent Crisis Intervention Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Independent crisis professional must meet the minimum provider qualifications under independent therapeutic consultation services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- Within 6 months of providing services to participants
- At least every 2 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▾

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Training

HCBS Taxonomy:

Category 1:

Sub-Category 1:

17 Other Services	17990 other	▼
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Category 2:

Sub-Category 2:

	▼
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Category 3:

Sub-Category 3:

	▼
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Category 4:

Sub-Category 4:

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Service Definition (Scope):

Family Training. Family training is professional one-on-one (1 on 1) instruction to families to help them better meet the needs of the waiver participant receiving intervention services.

- Family training is limited to training in the implementation of intervention techniques as outlined in the plan of service.

- Family training must be provided to the participant's parent or legal guardian when the participant is present.

- The parent or legal guardian of the waiver participant should participate in family training when the participant is receiving habilitative interventions.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Families should participate in family training when the participant is receiving habilitative interventions. The frequency for this service is determined by the family-centered planning team and the family, and is included on the plan of service.

Family training is subject to the participant's individual budget as defined in C-4.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Developmental Disabilities Agencies
Agency	Early Intervention

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training

Provider Category:

Agency 

Provider Type:

Developmental Disabilities Agencies

Provider Qualifications

License (specify):



Certificate (specify):

Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.

Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410.

In addition must meet the following qualifications to provide family training in a DDA:

- Must meet the minimum provider qualifications under habilitative intervention services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- A review within 6 months of providing services
- At least every 3 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training

Provider Category:

Agency 

Provider Type:

Early Intervention

Provider Qualifications

License (specify):



Certificate (specify):



Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410.

In addition must meet the following qualifications to provide family training:

- Must meet the minimum provider qualifications under habilitative intervention services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- Within 6 months of providing services to participants
- At least every 2 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Habilitative Intervention

HCBS Taxonomy:

Category 1:

Sub-Category 1:

17 Other Services	17990 other
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Category 2:

Sub-Category 2:

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Category 3:

Sub-Category 3:

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Category 4:

Sub-Category 4:

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Service Definition (Scope):

Habilitative intervention services must be consistent, aggressive, and continuous and are provided to improve a child's functional skills and minimize problem behavior. Services include individual or group behavioral interventions and skill development activity. Habilitative intervention must be based upon the well-known and widely regarded principles of evidence-based treatment. Evidence-based treatment (EBT) refers to the use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems.

Habilitative intervention must be provided to meet the intervention needs of the participant by developing adaptive skills for all participants, and addressing maladaptive behaviors for participants who exhibit them.

- When goals to address maladaptive behavior are identified on the plan of service, the intervention must include the development of replacement behavior rather than merely the elimination or suppression of maladaptive behavior that interferes with the child's overall general development, community, and social participation.
- When goals to address skill development are identified on the plan of service, the intervention must provide for the acquisition of skills that are functional.

Limitations:

- Habilitative intervention must be provided primarily in the participant's home or community setting, and in addition may be provided in a center-based setting.
- Group intervention may be provided in the community and center.
- Habilitative intervention services will not duplicate other Medicaid reimbursed services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Subject to the participant's individual budget defined in C-4.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Developmental Disabilities Agency
Agency	Early Intervention

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Habilitative Intervention

Provider Category:

Agency ▼

Provider Type:

Developmental Disabilities Agency

Provider Qualifications

License (specify):

Certificate (specify):

Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.

Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410.

In addition must meet the following qualifications to provide habilitative intervention in a DDA:

- Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college;
- Must be able to provide documentation of one (1) years supervised experience working with children with developmental disabilities;
- Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative intervention;
- Must satisfactorily complete a criminal history and background check

When services are provided to children birth - 3 staff are required to have:

- Minimum of two hundred forty (240) hours of professionally supervised experience with young children who have developmental disabilities and one (1) of the following:
 - An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or
 - A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or
 - A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content:

- o Promotion of development and learning for children from birth to three (3) years;
- o Assessment and observation methods for developmentally appropriate assessment of young children;
- o Building family and community relationships to support early interventions;
- o Development of appropriate curriculum for young children, including IFSP and IEP development;
- o Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and
- o Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development.
- o Electives closely related to Building family and community relationships to support early interventions may be approved by the Department with a recommendation from an institution of higher education.
- o Developmental specialists who possess a bachelor's or master's degree listed above, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement.
 - When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area:
The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- A review within 6 months of providing services
- At least every 3 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Habilitative Intervention

Provider Category:

Agency ▾

Provider Type:

Early Intervention

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410.

In addition must meet the following qualifications to provide habilitative intervention:

- Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college;
- Must be able to provide documentation of one (1) years supervised experience working with children with developmental disabilities;
- Must complete competency coursework approved by the Department to demonstrate competencies

related to the requirements to provide habilitative intervention;

- Must satisfactorily complete a criminal history and background check
- Minimum of two hundred forty (240) hours of professionally supervised experience with young children who have developmental disabilities and one (1) of the following:
 - An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or
 - b. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or
 - A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content:
 - o Promotion of development and learning for children from birth to three (3) years;
 - o Assessment and observation methods for developmentally appropriate assessment of young children;
 - o Building family and community relationships to support early interventions;
 - o Development of appropriate curriculum for young children, including IFSP and IEP development;
 - o Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and
 - o Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development.
 - o Electives closely related to Building family and community relationships to support early interventions may be approved by the Department with a recommendation from an institution of higher education.
 - o Developmental specialists who possess a bachelor's or master's degree listed above, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement.
 - When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area:
The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- Within 6 months of providing services to participants
- At least every 2 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

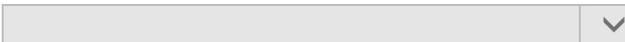
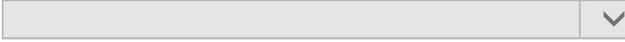
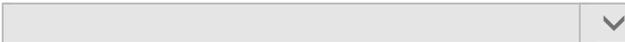
Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Interdisciplinary Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other 
Category 2:	Sub-Category 2:
	
Category 3:	Sub-Category 3:
	
Category 4:	Sub-Category 4:
	

Service Definition (Scope):

Interdisciplinary training is professional instruction to the direct service provider. Interdisciplinary training must only be provided during the provision of a support or intervention service. Interdisciplinary training is provided to assist the direct provider to meet the needs of the waiver participant.

Interdisciplinary training includes:

- Health and medication monitoring;
- Positioning and transfer;
- Intervention techniques;
- Positive Behavior Support
- Use of equipment

Limitations:

- Interdisciplinary training must only be provided to the direct service provider when the participant is present.
- Interdisciplinary training between a habilitative interventionist and a therapeutic consultant is not a reimbursable service.
- Interdisciplinary training between employees of the same discipline is not a reimbursable service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Interdisciplinary training is subject to the participant’s individual budget as defined in C-4.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Interdisciplinary Training Provider
Agency	Early Intervention
Agency	Developmental Disabilities Agency Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Interdisciplinary Training

Provider Category:

Individual 

Provider Type:

Interdisciplinary Training Provider

Provider Qualifications

License (specify):

The following professionals can provide interdisciplinary training:

- Occupational Therapist
- Physical Therapist
- Speech-Language Pathologist
- Practitioner of the Healing Arts as defined in Idaho Administrative Code, which includes a licensed physician, physician assistant or a nurse practitioner

Certificate (specify):

Other Standard (specify):

- Minimum provider qualifications under therapeutic consultation services or
- Minimum provider qualifications under habilitative intervention provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- Within 6 months of providing services to participants
- At least every 2 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Interdisciplinary Training

Provider Category:

Agency 

Provider Type:

Early Intervention

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410.

In addition must meet the following qualifications to provide interdisciplinary training:

- Occupational Therapist
- Physical Therapist
- Speech-Language Pathologist
- Practitioner of the Healing Arts as defined in Idaho Administrative Code, which includes a licensed physician, physician assistant or a nurse practitioner
- Habilitative Interventionist

- Therapeutic Consultant

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- Within 6 months of providing services to participants
- At least every 2 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Interdisciplinary Training

Provider Category:

Agency 

Provider Type:

Developmental Disabilities Agency Provider

Provider Qualifications

License (specify):

Certificate (specify):

Developmental Disabilities Agency (DDA) certificate as described in IDAPA 16.03.21

Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410.

In addition must meet the following qualifications to provide interdisciplinary training in a DDA:

- Occupational Therapist
- Physical Therapist
- Speech-Language Pathologist
- Practitioner of the Healing Arts as defined in Idaho Administrative Code, which includes a licensed physician, physician assistant or a nurse practitioner
- Habilitative Interventionist
- Therapeutic Consultant

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- A review within 6 months of providing services
- At least every 3 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service

not specified in statute.

Service Title:

Therapeutic Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
<input type="text" value="17 Other Services"/>	<input style="border-bottom: none; border-right: none; border-top: none;" type="text" value="17990 other"/> <input type="button" value="v"/>
Category 2:	Sub-Category 2:
<input type="text"/>	<input style="border-bottom: none; border-right: none; border-top: none;" type="text"/> <input type="button" value="v"/>
Category 3:	Sub-Category 3:
<input type="text"/>	<input style="border-bottom: none; border-right: none; border-top: none;" type="text"/> <input type="button" value="v"/>
Category 4:	Sub-Category 4:
<input type="text"/>	<input style="border-bottom: none; border-right: none; border-top: none;" type="text"/> <input type="button" value="v"/>

Service Definition *(Scope):*

Therapeutic consultation provides a higher level of expertise and experience to support participants who exhibit severe aggression, self-injury, and other dangerous behaviors. Therapeutic consultation is provided when a participant receiving habilitative intervention has been assessed as requiring a more advanced level of training and assistance based on the participant's complex needs. A participant requires therapeutic consultation when interventions are not demonstrating outcomes and it is anticipated that a crisis event may occur without the consultation service.

The therapeutic consultant assists the habilitative interventionist by:

- Performing advanced assessments as necessary;
- Developing and overseeing the implementation of a positive behavior support plan;
- Monitoring the progress and coordinating the implementation of the positive behavioral support plan across environments; and
- Providing consultation to other service providers and families.

Limitations:

- Therapeutic consultation cannot be provided as a direct intervention service.
- Participants must be receiving habilitative intervention services prior to accessing therapeutic consultation, with the exception of crisis situations.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Must be prior authorized by the Department
- Limited to 18 hours per year
- Excluded from the participant's budget

Service Delivery Method *(check each that applies):*

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by *(check each that applies):*

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

--

Provider Category	Provider Type Title
Agency	Early Intervention
Agency	Developmental Disabilities Agency Provider
Individual	Therapeutic Consultant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Therapeutic Consultation

Provider Category:

Agency ▼

Provider Type:

Early Intervention

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410.

In addition must meet the following qualifications to provide therapeutic consultation:

- Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program);
- Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior.
- Must satisfactorily complete a criminal history and background check

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- Within 6 months of providing services to participants
- At least every 2 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Therapeutic Consultation

Provider Category:

Agency ▼

Provider Type:

Developmental Disabilities Agency Provider

Provider Qualifications

License (specify):

^
v

Certificate (specify):

- Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.

Other Standard (specify):

Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", 16.03.21.410.

In addition must meet the following qualifications to provide therapeutic consultation in a DDA:

- Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program);
- Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior.
- Must satisfactorily complete a criminal history and background check

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- A review within 6 months of providing services
- At least every 3 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Therapeutic Consultation

Provider Category:

Individual v

Provider Type:

Therapeutic Consultant

Provider Qualifications

License (specify):

^
v

Certificate (specify):

^
v

Other Standard (specify):

- Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program);
- Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior.
- Must satisfactorily complete a criminal history and background check
- Must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter.
- Must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

- At initial provider agreement approval or renewal
- Within 6 months of providing services to participants
- At least every 2 years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

- b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- As an administrative activity.** *Complete item C-1-c.*

- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management is delivered by the Department of Health and Welfare and its contractors as an administrative activity.

For participants who choose family-direct, case management is included in the support broker services. As part of the case management services required by the support broker, the support broker must ensure that participants or their decision-making authority direct the development of their service plan through a person-centered planning process. The support broker (Case Manager) must provide information and support to the HCBS participant to maximize their ability to make informed choices and decisions. All family-directed services are authorized by the Department.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

- No. Criminal history and/or background investigations are not required.**
- Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

a) All waiver providers that provide direct care or services to participants, including independent providers and developmental disability agency staff must satisfactorily complete a criminal history and background check (completed by the Criminal History Unit of DHW) in accordance with Idaho Administrative Code at IDAPA 16.05.06:

1) Staff will fill out an application and submit it on-line or mail within twenty-one (21) days from the date of

notarization

2) The employer should screen applicants after applicant fills out the application prior to the staff providing services

The Department will review the application and results for the independent providers.

b) Criminal History Checks review information obtained from the Federal Bureau of Investigation, the National Criminal History Background Check System, the Idaho State Police Bureau of Criminal Identification, the statewide Child Abuse Registry, the Adult Protection Registry, the Sexual Offender Registry, and the Medicaid Surveillance and Utilization Review exclusion list.

c) Traditional waiver providers sign a written agreement to comply with all rules and regulations relevant to the services they provide. This includes compliance with IDAPA 16.05.06. Criminal history background checks are also reviewed during retrospective quality assurance surveys conducted by the Department.

a) Participants and families who choose to family-direct may waive this requirement for community support workers. In this case, the waiver of this requirement must be in writing and must be maintained by the Fiscal/Employer Agent. The waiver must be signed by the parent/legal guardian and must state; 1) why the parent/legal guardian is waiving the criminal history check, 2) how the parent/legal guardian will assure health & safety without obtaining the criminal history check, and 3) that the parent/legal guardian understands the risk with waiving the criminal history check and accepts this increased risk.

b) Additionally, for family-directed participants, the Department will monitor criminal history check waivers in the following ways:

- Participant outcome interviews will include a sampling of participants who have waived the criminal history check for a community support worker.

- The Department will receive a list of criminal history check waivers from the Fiscal/Employer Agent.

- The Department will conduct a search of the complaint/incident database for any complaints or incidents associated with the participants and community support workers who have a criminal history check waiver.

- Quality Oversight Reports to the Quality Oversight Committee will include an analysis of the impact of this waiver process.

c) For family-direction, prior to providing reimbursable services to the participant, the support broker and community support workers must submit a copy of the clearance letter received from the Department's Criminal History Check Unit or a copy of the completed criminal history background check waiver, as applicable.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The Idaho Department of Health & Welfare, Division of Family & Community Services is responsible for maintaining the Child Abuse Registry. The Adult Protection Registry is maintained by Idaho Commission on Aging.

(b) Criminal history checks include review of the abuse registries and criminal history checks are completed by the IDHW Criminal History Unit. The positions that require abuse registry screening are the same as positions requiring criminal history checks.

(c) The Idaho Department of Health and Welfare-Division of Family and Community Services maintains the Child Abuse Registry, and the Adult Commission on Aging maintains the Adult Abuse Registry. The Idaho Department of Health and Welfare- Criminal History Unit complete the criminal history check process, and the criminal history check process includes review of the registry.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. **Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to

ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.**

Specify:

Respite is the only waiver service that may be provided by relatives of a participant. A parent or legal guardian cannot furnish waiver services, but a relative may be paid to provide respite services whenever the relative is qualified to provide respite as specified in Appendix C-1/C-3. There are numerous safeguards in place to ensure that payments are only made for services rendered including oversight by provider agencies, family-centered planning teams, circles of supports, fiscal/employer agent, and by the Department through review and approval of plans of service and retrospective quality assurance reviews.

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

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Lists of current providers are available from the IAP and regional offices. This list is also posted on the children's DD services website: www.childrensDDservices.dhw.idaho.gov. Provider qualifications and requirements are published in the Department's Administrative Rules and are available online at <http://adm.idaho.gov/adminrules/rules/idapa16/16index.htm>. Specific Medicaid provider information, including provider handbooks and Molina provider enrollment information, is available on the Department of Health and Welfare website at www.healthandwelfare.idaho.gov by clicking on the "Providers" button, then "Medicaid Providers" link.

To become a certified provider the agency will submit an application to the Department of Health and Welfare, licensing and Certification. The application is located at: www.healthandwelfare.idaho.gov, click "Providers" button, click "Developmental Disabilities & Residential habilitation Agencies". To apply to be an independent Respite, Therapeutic Consultation or Crisis Intervention Provider the person will submit an application to Family and Community Services. These applications are located at www.childrensDDservices.dhw.idaho.gov under "Information for Providers".

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

- a. Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. **Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of initial certified waiver providers that meet certification standards prior to providing services. a. Numerator: Number of initial waiver providers that meet required certification standards prior to providing services. **b. Denominator:** Number of initial waiver providers requiring certification.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of ongoing waiver providers that meet certification standards

- a. Numerator: Number of ongoing waiver providers that meet certification standards
 b. Denominator: Number of ongoing waiver providers surveyed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Licensing and Certification reporting

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

		<input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of initial, non-certified waiver providers that received an initial provider review within 6 months of providing services to participants. a. Numerator: Number of initial, non-certified waiver providers that received a review within 6 months of providing services to participants. b. Denominator: Number of initial, non-certified providers.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):

<i>(check each that applies):</i>		
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of non-certified waiver providers that received a quality review every two years. a. Numerator: Number of non-certified waiver providers

that received a quality review in the waiver year. b. Denominator: Number of non-certified waiver providers reviewed.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Other
Specify:

- c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver providers that meet state requirements for training.

- a. Numerator: Number of waiver providers reviewed that meet state requirements for training. b. Denominator: Number of waiver providers reviewed.**

Data Source (Select one):

Other

If 'Other' is selected, specify:

Licensing and Certification report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

	<input style="width: 90%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 90%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 90%; height: 20px;" type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
 The Department reviews all independent providers within 6 months of providing services and every 2 years. If a service or training deficiency is found during a review of a non-certified provider, a Plan of Correction (POC) is initiated by the Department, the provider must submit the POC ten (10) business days from initiation. The POC must include a response to each deficiency stating:
 - What actions will be taken
 - Who will be responsible for the corrective action
 - How the corrective actions will be monitored to ensure consistent compliance with Idaho Code
 - Dates the corrective action will be completed
 - What type of evidence of documentation will be provided to the Department documenting that the corrective action plan has been implemented.

If the review reveals issues that potentially put the participant’s health and safety at risk, mandatory reporting laws must be followed, and the incidents must be recorded in the critical incident/complaint database.

Licensing and Certification (L&C) conducts a survey on all Developmental Disability Agencies (DDA) within the first 6 months of providing services and those DDA’s whose certification expires within that waiver year. During this survey L&C will identify if the agency will be re-certified and will issue citations for non-compliance with training requirements which must be submitted to the Department within 14 days of receiving a statement of deficiency from the Department. The Department also follows an enforcement and remedies process when discovering that a Developmental Disabilities Agency (DDA) has not met rule or finds that the

DDA's deficiencies immediately jeopardize the health and safety of its participants.

The data for these indicators are collected through quarterly and annual reports and reviews.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable-** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit

based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. *(check each that applies)*

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

a) Traditional waiver services included in the budget amount are respite, habilitative supports, family education, habilitative intervention, family training, and interdisciplinary training.

Therapeutic consultation and crisis intervention services are excluded from the budgets.

If the family chooses to family-direct their services, community support worker, paid support broker, and F/EA services are included in the budget.

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

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

The sample findings were applied to the general Children's DD population, and the budgets were distributed based upon the service level needs of the participants and funds available.

The children's budget methodology is driven by evidence-based research and is reflective of the children's continuum of services developed under the program. The continuum of services create a system based on needs as children's needs become more involved they are able to access a wider array of services and the budget levels are increased accordingly.

Research suggests that intervention addressing maladaptive behaviors for children may demonstrate outcomes. The Children's DD waiver budgets are structured to align with those needs based on diagnosis and the characteristics of the child. For example, children with behavioral issues will have additional resources available for them to access intervention services.

The Department monitors the budgets on an ongoing basis to ensure that children's needs are accurately being reflected. The budget setting methodology is evaluated on an annual basis using tracking reports established

by the Department. This information is used to help the state identify improvements if needed. The state has identified the following three categories for the children's DD waiver:

Level I – \$6,200

Children meeting ICF/ID level of care criteria who qualify based on functional limitations when their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or

Children who have an overall age equivalency up to fifty-three percent (53%) of their chronological age when combined with a General Maladaptive Index between minus seventeen (-17), and minus twenty-one (-21) inclusive.

Level II – \$8,400

Children meeting ICF/ID level of care criteria who qualify based on functional limitations when their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; and

Have an autism spectrum disorder diagnosis.

Level III – \$14,900

Children meeting ICF/ID level of care criteria who qualify based on maladaptive behaviors when their General Maladaptive Index is minus twenty-two (-22) or less.

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

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

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

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

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

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

The Department has also built safeguards into the waiver for outlier cases, where children who have complex conditions may require more specialized services or increased supports beyond what is accounted for in the budget. For this reason the waiver offers services that are not subject to a child's budget that are available for families where it is found the budgeted services may be insufficient to meet their child's needs.

Therapeutic consultation is a service that provides advanced assessments and planning for children who are not demonstrating outcomes with their current treatment. The case manager will work with the family to

determine if this specialized service could benefit the child, and the cost of the service is excluded from the budget. The case manager may identify that additional services are needed for any number of reasons, such as recommendations from the family or service providers, changes in the child's condition, or during plan monitoring as part of progress review.

Crisis intervention services are also available outside of the child's budgets to act as a safeguard for children requiring additional support. The Department has a crisis network team that is utilized to case manage identified children in crisis. Crisis intervention may be provided by a Developmental Disability Agencies (DDA), independent provider, and/or early intervention provider, to provide support and intervention services.

- Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

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Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

See Attachment #2.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Plan of Service

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**
- Licensed practical or vocational nurse, acting within the scope of practice under State law**
- Licensed physician (M.D. or D.O)**
- Case Manager** (qualifications specified in Appendix C-1/C-3)
- Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

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- Social Worker**

Specify qualifications:

Other

Specify the individuals and their qualifications:

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

Traditional Waiver Services:

The family has a choice of who will develop the plan of service. They can utilize a case manager with the Department/contractor, choose a non-paid plan developer, or develop their own plan. The plan developer is responsible for developing one plan of service that cover all services and supports based on the family-centered planning process.

Non-paid plan development may be provided by the family, or a person of their choosing, however this person cannot be a paid provider of services identified on the child's plan of service.

The case manager with the Department or it's contractor must have a minimum of a Bachelor's Degree in a human services field from a nationally accredited university or college and have 24 months supervised experience working with children with disabilities, and pass a Department criminal history background check.

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

Family-Directed Waiver Services:

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Select one:

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: SERVICE PLAN DEVELOPMENT (4 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

TRADITIONAL SERVICES:

a) Participants who select traditional waiver services receive an orientation about the developmental disability services during the eligibility process by the IAP. The participant or their decision-making authority must direct the development of their service plan through a person-centered planning process. The plan developer must provide information and support to the HCBS participant to maximize their ability to make informed choices and decisions. Individuals invited to participate in the person-centered planning process should be identified by the participant or the participant's decision-making authority.

b) Family-centered planning must include at a minimum the participant, the participant's decision making authority and the plan developer. The plan developer is responsible on notifying the providers who appear on the plan of service of the annual review date. With the participant's decision making authority's consent, the family-centered planning team may also include additional family members or individuals who are significant to the participant.

FAMILY-DIRECTED SERVICES

a) Participants and families who choose family-direction receive an orientation on family-direction and "My Voice My Choice" training from the Department. Families may select a qualified support broker to assist with writing the Support and Spending Plan, or they may choose to become a qualified support broker approved by the Department. As outlined in IDAPA 16.03.13, "Consumer-Directed Services," the participant's decision making authority decides who will participate in the planning sessions in order to ensure the participant's choices are honored and promoted.

b) The participant or decision making authority must direct the development of their service plan. The participant or the participant's decision making authority may choose to facilitate the person-centered planning meetings, or have the meetings facilitated by the chosen support broker. In addition, the participant and the participant's decision making authority select a circle of support. Members of the circle of support commit to work within the group to: help promote and improve the life of the participant in accordance with the participant's choices and preferences; and meet on a regular basis to assist the participant and family to accomplish their expressed goals.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) In both the traditional and family-directed options, the plan is developed by the participant and their decision-making authority with their support team through the person-centered planning process. The support team is typically comprised of the plan developer or a support broker, the participant's decision making authority, the participant, at least one involved care giver and any friends, family or support staff that the family wants to invite. The number of people who can be involved is not limited. Besides the participant and the participant's decision making authority, the plan developer is the only person who is required to be a member of the support team.

For both traditional services and consumer directed services, the person-centered planning process must:

- Be conducted timely and occur at convenient times and locations to the participant and the participant's decision-making authority
- Reflect cultural considerations of the participant.
- Be conducted by providing information in plain language and in a manner that is accessible to participants with

disabilities and persons who are limited English proficient as defined in 42 CFR 435.905(b).

Plan developers and support brokers must, if needed, utilize strategies for solving conflict or disagreement within the process, and follow clear conflict-of-interest guidelines for all planning participants.

All person-centered service plans must include:

- Clinical services and supports that are important for the participant's behavioral, functional, and medical needs as identified through an assessment.
- Indication of what is important to the participant with regard to the service provider and preferences for the delivery of such services and supports.
- Documentation of the HCBS setting selected by the participant or the participant's decision-making authority and indication the setting was chosen from among a variety of setting options. The person-centered service plan must identify and document the alternative home and community setting options that were considered by the participant, or the participant's decision-making authority.
- Participant strengths and preferences.
- Individually identified goals and desired outcomes.
- Paid and unpaid services and supports that will assist the participant to achieve identified goals, and the providers of those services and supports, including natural supports.
- Risk factors to the participant as well as people around the participant and measures in place to minimize them, including individualized back-up plans and strategies when needed.
- The name of the individual or entity responsible for monitoring the plan.
- Documentation that the plan is finalized and agreed to, by the participant, or the participant's decision-making authority, in writing, indicating informed consent. The plan must also be signed by all individuals and providers responsible for its implementation indicating they will deliver services according to the authorized plan of service and consistent with home and community based requirements.

All person centered service plans must be understandable to the participant receiving services and supports, and the individuals important in supporting him or her. At a minimum, the written plan must be understandable, and written in plain language in a manner that is accessible to participants with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b). The plans are distributed to the participant and the participant's decision-making authority, if applicable, and other people involved in the implementation of the plan.

(b) The IAP conducts and/or collects a variety of assessments at the time of initial application and on an annual basis, as noted, for both the traditional waiver services and the family-directed option.

The IAP conducts the following assessments at the time of the initial application for DD waiver services:
Scales of Independent Behavior-Revised (SIB-R) functional assessment.
Medical, Social and Developmental Assessment Summary.

At the time of annual re-determination, the IAP conducts and/or reviews the following:
The Medical, Social and Developmental Assessment Summary is reviewed and updated.
The SIB-R results are reviewed and another assessment performed if there are significant changes in the participant's situation or the reassessment criteria are met.

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

Psychological evaluations, including evaluations regarding cognitive abilities, mental health issues and issues related to

traumatic brain injury.

Neuropsychological evaluations.

Physical, occupational and speech-language pathology evaluations.

Developmental and specific skill assessments.

Participants using traditional waiver services, and their support team, must complete a health and well-being checklist which assess and documents health and safety issues. Participants using the family-directed option, and their support team, must complete safety plans related to any identified health and safety risks and submit them to the Department.

In the traditional waiver option, the participant and family's needs, goals, preferences and health status are summarized

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

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

(c) Participants and families, along with other members of the support team can receive information regarding the waiver services through several methods:

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

The Department of Health and Welfare web site also has a page specific for family-directed services found at: <http://healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities/FamilyDirectedServices/tabid/213/Default.aspx>.

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

The plan developer is charged with verbally explaining the various programs and options to the participant and family during the family-centered planning process, under the traditional option.

The support broker is charged with assisting the participant to assess what services meet their needs, under the family-direction option.

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

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

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

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

Under the traditional option the responsibility of coordination is placed on the plan developer, IAP, and the Department.

The IAP is responsible to submit the assessment and individual budget to the Department.

The plan developer is responsible to:

Ensure that services are not duplicative, and are complementary and appropriate

Work with the members of the family-centered planning team and providers to ensure that the service needs of the participant

are reflected on the plan of service

Act as the primary contact for the family and providers
Link the family to training and education to promote the family's ability to competently choose from existing benefits
Complete a comprehensive review of the child's needs, interests, and goals
Assist the family to allocate funding from their child's individual budget
Monitor the progress of the plan of service
Ensure that changes to the plan of service are completed when needed
Facilitate communication between the providers in the child's system of care

If the family writes the child's plan or choose a non-paid plan developer the case manager will assist them with the above tasks as needed.

The plan developer is also responsible for identifying if additional services are needed beyond the child's budgeted services. These services may include therapeutic consultation, crisis intervention, or services outside of the waiver program. The plan developer identifies additional services are needed for any number of reasons, such as recommendations from the family or service providers, changes in the child's condition, or during plan monitoring as part of progress review. If it is found that the child would benefit from these other services, the plan developer will assist families with locating a qualified provider and amending the plan to include the new benefits.

Under the family-directed option, the responsibility is placed on the participant and family to coordinate services with assistance from the Department and the Fiscal/Employer Agent (F/EA) as required.

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

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Prior to the family-centered planning process the child has been determined eligible for DD services and has received a budget for these services. The child's developmental disability services are coordinated at the time of plan of service development. The plan of service also contains a list of coordinated services which are Medicaid and non-Medicaid services. These services are discussed to determine needs for referral and coordination of assessments and needs. Risk assessment is also evaluated as part of the family-centered planning process. Team members identify risks as part of the discussion for the plan of service or Support and Spending Plan. Emergency back-up for support, and plans to mitigate identified risks are identified on the plan. Specific information is identified on the implementation plans developed by providers for traditional waiver services or on the back-up plans for participants who family-direct. To assist with identification of risks the Department uses a health and well-being checklist. This checklist is incorporated in the plan of service and looks at medical issues, supervision needs, abuse risks, risks that result from behavior issues with the participant, exploitation risks, and financial risks. Along with identification, the checklist also identifies how the risk is being mitigated.

Therapeutic consultation is a service that provides advanced assessments and planning for children who are not demonstrating outcomes with their current treatment and it is anticipated that a crisis event may occur without the consultation. The plan developer will work with the family to determine if this specialized service could benefit the child.

Crisis intervention services are also available outside of the child's budget to act as a safeguard for children requiring additional support. The Department has a crisis network team that is utilized to case manage identified children in crisis. Crisis intervention may be provided by a Developmental Disability Agencies (DDA), independent provider, and/or early intervention provider, to provide support and intervention services.

Provider agencies are responsible to provide for health and safety and quality assurance for the participants they serve. The rules and regulations along with provider agreements assure that the providers are responsible to provide for safe and effective services and have processes in place to assure quality. The service provider is responsible for ensuring that any risks posed to the participant by the home and community-based setting requirements described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," and corresponding mitigation strategies are justified and documented appropriately in the service plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

All proposed service plans must be reviewed and approved by the Department. Prior to this approval, no services may be provided or billed. Once the Department authorizes the plan of service they will enter the prior authorization into the Medicaid Management Information System (MMIS).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a) The family, case manager, or the nonpaid plan developer are responsible for monitoring the plan and participant's health and welfare ongoing.

b) Plan monitoring includes:

- Review of the plan of service with the participant and family to identify the current status of programs and changes if needed.
- Contact with service providers to identify barriers to service provision.
- Discussion on participant satisfaction regarding quality and quantity of services. For example, when the participant and family expresses interest in changing providers, the case manager or nonpaid plan developer will assist them in exploring other provider options available to the family.
- Review of provider status reviews after the six month review and for annual plan development. At the six month and

annual review, the plan developer compiles results from providers as part of the monitoring process.

- Ensuring back-up plans are in place and implemented as necessary.
- Ensuring that all services and supports listed on the plan of service, including the non-waiver services are being accessed and that collaboration is taking place among all providers in the child's system of care.
- When problems are identified, the case manager will follow the appropriate Department procedure for reporting complaints and critical incidents, including contacting the crisis network team when it is discovered that the participant and/or family are in a crisis situation. If a family or non-paid plan developer identifies a problem they will make a report to the case manager who will then follow the appropriate Department procedure for reporting complaints and critical incidents.

Participants and families who choose to family-direct are responsible for monitoring services with the assistance of their circle of supports. Participants may also choose to employ a support broker to perform some or all of these monitoring activities.

c) For traditional services, the case manager or nonpaid plan developer monitors the plan at a frequency determined by the family-centered planning team, and as authorized on the plan of service. The case manager or nonpaid plan developer must make direct, in-person contact with the participant at least annually, but plan monitoring may occur more frequently as needed.

In family direct, the participant and circle of supports determine the frequency and methods for monitoring. The Department reviews the proposed Support and Spending Plan. If this plan does not detail sufficient monitoring to protect the participant's health and safety, the Department asks for additional detail and appropriate changes to the proposed plan prior to authorization.

The Department also reviews and investigates critical incident reports and complaints and conducts ongoing children's service outcome reviews. A representative sample of all waiver participants is reviewed on an ongoing basis.

b. Monitoring Safeguards. Select one:

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of service plans reviewed that address participants' needs and health and safety risk factors identified in the individual's assessment(s) a.

Numerator: Number of service plans reviewed that document participants' needs and health and safety risk factors identified in the individual's assessment(s) b.

Denominator: Number of service plans reviewed in the representative sample

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% and a confidence level of 95%.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	<input type="text"/>

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of service plans reviewed that addressed potential and real risks and had back up plan interventions in place. a. Numerator: Number of service plans reviewed that addressed potential and real risks and had back up plan interventions in place. b. Denominator: Number of service plans reviewed in the representative sample.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% and a confidence level of 95%.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify:	
	<input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
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<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/> <input type="button" value="↑"/> <input type="button" value="↓"/>

Performance Measure:

Number and percent of service plans reviewed that address participants' personal goals. a. Numerator: Number of service plans reviewed that address participants' personal goals. b. Denominator: Number of service plans reviewed in the representative sample.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% and a confidence level of 95%.
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
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<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of service plans that were revised when warranted by changes in participant’s needs. a. Numerator: Number of service plans that were revised when warranted by changes in the participant’s needs. b. Denominator: Number of service plans in the representative sample requiring revision as warranted by changes in participants' needs.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% and a confidence level of 95%.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):

<i>(check each that applies):</i>		
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% and a confidence level of 95%.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
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<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of service plans reviewed that indicate services were delivered consistent with the service type, scope, amount, duration and frequency approved on service plans. a. Numerator: Number of plans reviewed that indicate services were delivered consistent with the approved plans. b. Denominator: Number of plans reviewed in the representative sample.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% and a confidence level of 95%.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for	Frequency of data	Sampling Approach
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data collection/generation <i>(check each that applies):</i>	collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% and a confidence level of 95%.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
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<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

e. *Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and*

between/among waiver services and providers.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of participant records reviewed that indicated participants were given a choice when selecting waiver service providers. a. Numerator: Number of participant records reviewed that indicated participants were given a choice when selecting service providers. b. Denominator: Number of participant records reviewed in the representative sample.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% and a confidence level of 95%.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of participant records reviewed that indicated participants were given a choice when selecting waiver services. a. Numerator: Number of participant records reviewed that indicated participants were given a choice between waiver services b. Denominator: Number of participant records reviewed in the representative sample.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% and a confidence level of 95%.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

		<input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Quality assurance staff with the Department conducts a Children's Services Outcome Review (CSOR) annually on a statistically valid sample of participants. The CSOR is a tool for quality improvement which focuses on collecting information directly from the participant and their caregivers, reviewing demographic and medical/social history from the participant's files to ensure accuracy of records and an observation of the services provided to the child.

The CSOR includes:

- Child File review: The child's file is reviewed to assess and determine if the timeframes for plan assessment, development, review and monitoring are met. Utilization is also reviewed
- Parent Satisfaction: Parents are contacted to assess the services their child receives. The questions address satisfaction with case management, independent assessment and services providers as well as knowledge of the services, systems available and safety reporting procedures. Parent report can trigger follow-up with the case manager or providers to assure the child's needs are met.
- Observation: Observation of services are completed to determine if the services delivered by the providers meet the child's need, and are consistent to the service type, scope, amount, duration, and frequency approved within the service plan

If items are identified as deficient during the reviews, an Enhanced review will be conducted.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

If areas of concern are identified during the children's service outcome review, an enhanced review is conducted for further investigation. Enhanced Review provides an opportunity for the FACS QA staff to further investigate determinations that an indicator is accurate as identified from the children services outcome review (CSOR). This further investigation involves document review, interviews and/or observation which may elicit evidence to clarify the validity of the participant's response. After the enhanced review is completed the FACS QA staff will determine if the response was valid, if there is necessary remediation that has been identified, or if the issue has already been remediated. If a service deficiency is found, a Plan of Correction (POC) is initiated by the Department and must be submitted within 10 days of the initiation. The POC must include a response to each deficiency stating:

- What actions will be taken,
- Who will be responsible for the corrective action,
- How the corrective actions will be monitored to ensure consistent compliance with Idaho Code,
- Dates the corrective action will be completed, and
- What type of evidence of documentation will be provided to the Department documenting that the corrective action plan has been implemented.

QA staff will follow up with the provider within 45 days of the POC submission to assure that the plan for correction has been implemented. If the provider fails to implement the corrective action plan within a 45 day period the child's authorization of services could be terminated with that specific provider. In addition, depending on the lack of compliance, the Department may immediately terminate the provider agreement. The operating entity QA staff could make a referral to Medicaid Integrity Program Unit, and if the service deficiency affects a provider who is certified, the operating team would refer the provider to the Division of Licensing and Certification.

If the review reveals issues that potentially put the participant's health and safety at risk, mandatory reporting laws must be followed, and the incidents must be recorded in the critical incident/complaint database.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.**
- No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

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

b) Once participants are determined eligible for the waiver, an individualized budget is developed for each participant that incorporates an individual budget methodology that is calculated consistently. The budget model provides participants with an individual budget and a maximum level of funding that varies according to individual needs. This allows for spending flexibility within the set budgeted dollars according to participant's needs and preferences. The support need is determined from an evaluation completed using a uniform assessment tool. Upon completion of a participant's individual assessment, the individualized budget methodology which the Department uses to determine an individual's budget is reviewed with the participant and family either by an IAP representative or a Department staff.

c) Participants then have the option to choose Family-Directed Services (FDS). The FDS option allows eligible participants and families to choose the type and frequency of supports they want, to negotiate the rate of payment, and to hire the person or agency they prefer to provide those supports. Participants and families must use a support broker to assist them with the family-directed process. This can be accomplished in one of two ways: The family may choose to hire an approved support broker to perform specific duties as needed, or the family may choose to act as an unpaid support broker with the ability to perform the full range of support broker duties. If a parent/legal guardian wishes to act as an unpaid support broker for the participant, they must complete the support broker training and be approved by the Department. Paid support broker services are included as part of the community support services that participants

may purchase out of their allotted budget dollars.

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

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

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

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

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

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

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

My Emotional Needs – addresses strategies in assisting an individual to learn and increasingly practice behaviors consistent with the person's identified goals and wishes while minimizing interfering behaviors.

My Learning Needs - identifies activities that support an individual in acquiring new skills or improving established skills that relate to a goal that the person has identified.

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.*Select one:*

- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services**E-1: Overview (3 of 13)****d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

- Waiver is designed to support only individuals who want to direct their services.**
- The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services**E-1: Overview (4 of 13)**

- e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a

timely basis.

The Department holds regular informational meetings where participants and families can learn about family-direction. Participants are also provided with informational materials during their initial and annual level of care determinations by the Department. These materials include information about selecting either the traditional pathway or the family-directed pathway and include a self-assessment tool.

This self-assessment tool helps participants assess potential benefits, risks and responsibilities with selecting family-direction. Participants and families who express interest in family-direction will have a one-on-one orientation meeting with Department staff. At this meeting, families will receive information that will guide them through the family-direction process of selecting a support broker or becoming a support broker, hiring community support workers, and utilizing Financial Management Services.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Community Support Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Support Broker Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Financial Management Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. **Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

- Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.**
Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:
Financial Management Services

- FMS are provided as an administrative activity.**

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

The Department enters into provider agreements with any qualified financial management service provider to provide Financial Management Services to participants who elect to family-direct. For HCBS waiver participants who choose the family-directed services (FDS) option, entities that furnish financial management services must be qualified to provide such services as indicated in section 3504 of the Internal Revenue Code as an F/EA.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The financial management service (FMS) will file a claim through Molina for each fiscal employer agent service provided. The FMS will receive reimbursement from Molina for the services billed.

- iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- Assist participant in verifying support worker citizenship status**
- Collect and process timesheets of support workers**
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- Other**

Specify:

Establishing and maintaining an employment record for each paid community support that contains the employment application package, copies of licenses or certification as required, completed criminal history check or waiver, as applicable, time sheets, billing records, payment records, and required state and federal employment related documentation.

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's participant-directed budget**
- Track and report participant funds, disbursements and the balance of participant funds**
- Process and pay invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

Specify:

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- Other**

Specify:

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

a-b)The Department enters into provider agreements with qualified financial management service providers to perform financial management services for participants and families who choose to family-direct. Financial management service provider duties and responsibilities are outlined in IDAPA rule chapter 16.03.13 which includes:

- Payroll and Accounting
- Financial Reporting
- Information Packet
- Time sheets and Invoices
- Taxes
- Payments for goods and services
- Spending information
- Quality Assurance and improvement

The Department monitors the activities of each financial management service provider through the following methods:

- Audits of transactions performed by each financial management service provider through selection of a random sample of participants and review of records and transactions that each financial management service provider has completed on behalf of those participants who have selected them as their provider. The audit methodology will use statistically valid standards to assure that the sample is random and of sufficient size to achieve statistical significance.

- Requiring that each financial management service provider ensure the quality of the financial management services performed on behalf of all participants, and they must review the results of these internal quality assurance activities.

- Assessment of participant satisfaction with the services provided by each financial management service provider as part of the children's service outcome reviews.

c) Formal assessment of each financial management service provider will occur at least every 2 years and on an as needed basis.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (*check each that applies*):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Respite	<input type="checkbox"/>
Community Support Services	<input type="checkbox"/>
Family Education	<input type="checkbox"/>
Family Training	<input type="checkbox"/>
Therapeutic Consultation	<input type="checkbox"/>
Habilitative Supports	<input type="checkbox"/>
Habilitative Intervention	<input type="checkbox"/>
Interdisciplinary Training	<input type="checkbox"/>
Support Broker Services	<input checked="" type="checkbox"/>
Financial Management Services	<input checked="" type="checkbox"/>
Crisis Intervention	<input type="checkbox"/>

- Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (*select one*).

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

As described in IDAPA 16.03.13, the continuation of the use of consumer-directed community supports could be jeopardized if:

- 1) a participant's support and spending plan is consistently not followed,
- 2) a participant has identified risks though has no back-up plan(s) to manage the risks and the participant's safety OR
- 3) the participant's choices directly endanger the participant's health, welfare, and safety or endanger or harm others.

In these cases, the Department will work closely with the participant, family, and support broker to identify necessary changes to the plan of service, authorize emergency services if necessary, and facilitate any other activities necessary to assure continuity of services during this transition.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
	Number of Participants	Number of Participants
Year 1	<input type="text"/>	380
Year 2	<input type="text"/>	403
Year 3	<input type="text"/>	426
Year 4	<input type="text"/>	449
Year 5	<input type="text"/>	472

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

- a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

- i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

- ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**
- Refer staff to agency for hiring (co-employer)**
- Select staff from worker registry**
- Hire staff common law employer**
- Verify staff qualifications**
- Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The identified community support worker will be responsible for paying for the criminal history

background check.

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- Determine staff wages and benefits subject to State limits**
- Schedule staff**
- Orient and instruct staff in duties**
- Supervise staff**
- Evaluate staff performance**
- Verify time worked by staff and approve time sheets**
- Discharge staff (common law employer)**
- Discharge staff from providing services (co-employer)**
- Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget**
- Determine the amount paid for services within the State's established limits**
- Substitute service providers**
- Schedule the provision of services**
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- Identify service providers and refer for provider enrollment**
- Authorize payment for waiver goods and services**
- Review and approve provider invoices for services rendered**
- Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The same budget methodology used for the traditional option is applied for the family-directed services option.

Community support worker, paid support broker, and F/EA services are included in the family-directed services budget.

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

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

The sample findings were applied to the general children's DD population, and the budgets were distributed based upon the service level needs of the participants and funds available.

The children's budget methodology is driven by evidence-based research and is reflective of the children's continuum of services developed under the waiver services. The continuum of services creates a system based on needs. When children's needs become more involved they are able to access a wider array of services and the budget levels are increased accordingly.

Research suggests that intervention addressing maladaptive behaviors for children may demonstrate outcomes. The children's DD waiver budgets are structured to align with those needs based on diagnosis and the characteristics of the child. For example, children with behavioral issues will have additional resources available for them to access intervention services.

The Department monitors the budgets on an ongoing basis to ensure that children's needs are accurately being reflected. The budget setting methodology is evaluated on an annual basis using tracking reports established by the Department. This information is used to help the state identify improvements if needed. The state has identified the following three categories for the children's DD waiver:

Level I – \$6,200

Children meeting ICF/ID level of care criteria who qualify based on functional limitations when their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or Children who have an overall age equivalency up to fifty-three percent (53%) of their chronological age when combined with a General Maladaptive Index between minus seventeen (-17), and minus twenty-one (-21) inclusive.

Level II – \$8,400

Children meeting ICF/ID level of care criteria who qualify based on functional limitations when their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; and Have an autism spectrum disorder diagnosis.

Level III – \$14,900

Children meeting ICF/ID level of care criteria who qualify based on maladaptive behaviors when their General Maladaptive Index is minus twenty-two (-22) or less.

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

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

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

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

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

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

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

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

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

An applicant who chooses the family-directed pathway will be notified of their eligibility for waiver services and given an annual individual budget at the time of their initial determination or annual re-determination. As outlined in Appendix C-4.a, participants who believe that their assigned budget does not accurately reflect their needs may appeal the assigned budget decision and request a fair hearing. The assigned budget is modified appropriately based on the outcome of the appeal process. Families always have the opportunity to choose a traditional pathway.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The participant and family's selected Fiscal Employer Agent will have the individual budget and the approved supports and services from the support and spending plan. They will send statements to participants on a monthly basis to inform them on the status of expenditures. The support broker will assist the family to review these statements to assure spending is on track. Employment agreements are developed for each community support worker that are descriptive to what is expected and how they will be paid.

As part of the QA process, the Quality Assurance (QA) manager monitors to assure that processes are in place to monitor these expenditures. Each fiscal agent is required to: 1) Have a system in place to perform a quarterly quality management (QM) analysis activity on a statistically significant sample of overall participant records; 2) Have documented, approved policies and procedures with stated timeframes for performing a quarterly quality management analysis activity on a statistically significant sample of overall participant records; 3) Have internal controls documented and in place for performing a quarterly QM analysis activity on a statistically significant sample of overall participant records; 4) Forward QM reports to the Department within thirty (30) working days from the end of each quarter. In addition to reviewing these quarterly reports, the Department also conducts a full service performance check on each fiscal agent provider at least every two years (all policies and procedures, and all the task and services as agreed upon in the provider agreement).

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Participants are given the opportunity to appeal any Department decision that adversely affects their waiver eligibility or waiver services. Participants are sent a notice anytime an adverse action is made regarding their choice of HCBS vs. institutional services; their choice of provider or service; and for any denial, reduction, suspension, or termination of service. In addition, participants who do not meet ICF/ID Level of Care criteria for waiver eligibility receive an initial or annual notice

stating they have been denied ICF/ID level of care. Department notices are provided to the participant and family in writing and contain information on appealing Department decisions that negatively affect eligibility or services. These notices include information that the participant may request to continue services during the appeal process. The notice of decision includes the following statement:

"If you request an administrative hearing, you may continue receiving benefits until the hearing is held and a decision is mailed to you. If the hearing officer decides that the Departments decision was correct, the Department may take action to collect from you the cost of the benefits you continued to receive as allowed by 42 C.F.R. 431.230.(b)"

Copies of these notices are maintained in the participant file. Individuals who wish to appeal a Departments decision have twenty-eight (28) days from the date the decision is mailed to file an appeal.

Participants and the public may learn more about the Department's fair hearing processes and policies by going to the children's developmental disabilities page at www.childrensDDservices.dhw.idaho.gov. Families may request assistance from the Department case Managers on pursuing the fair hearing process. In addition, the information distributed by the IAP, as well as the application for children's DD services describes the participant's right to appeal any Department decision that negatively affects their eligibility or services.

Once the Department receives the request for an appeal they will contact the family to discuss the case and a possible resolution prior to sending the formal paperwork to schedule a hearing. If the family would still like to pursue the fair hearing, the Department offers assistance by sending the family forms explaining the process and following up as needed. All parties in an appeal will be notified of a hearing at least ten (10) days in advance.

In addition, the Administrative Procedures Section (APS) within the Department provides assistance for families regarding the fair hearing process. Case managers and the APS are responsible for tracking all communications and requests for individuals pursuing a fair hearing.

In the fair hearing process, a hearing officer acts as an impartial third party in reviewing Department actions. The Department and the parent/legal guardian each have the opportunity to present his/her case before the hearing officer. The hearing officer considers testimony and evidence presented during hearing along with the pertinent state rules and federal regulations in making a decision.

A written preliminary decision is issued by the hearing officer and is sent to the Department and to the family. Either party may appeal that preliminary decision to the Department Director. The Director's decision is the final administrative remedy. When all administrative remedies are exhausted, the parent/legal guardian may appeal the final decision by requesting a judicial review by the District Court.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*
- No. This Appendix does not apply**
 - Yes. The State operates an additional dispute resolution process**
- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- No. This Appendix does not apply
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

Department of Health and Welfare

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Participants may register any and all types of grievances/complaints by telephone, fax, email, mail, or in person. When a complaint is received by the Department a determination will be made as to the severity of the complaint.

If the complainant alleges there is reasonable cause to believe that a child under the age of eighteen (18) years has been abused, abandoned or neglected or who observes the child being subjected to conditions or circumstances which would reasonably result in abuse, abandonment or neglect, the complainant shall report or cause to be reported within twenty-four (24) hours such conditions or circumstances to the proper law enforcement agency or the department.(Idaho Statute 16-1605, Juvenile Proceedings, Child Protective Act).

Complaints or grievances which fall within the following guidelines will be handled in the formal process as stated above:

- The issue must involve a potential for abuse, neglect, or exploitation of a participant OR
- Fraudulent use of a participant's Medicaid benefits AND
- Action must be taken by the staff person either to resolve the complaint or to refer the complaint outside the unit for resolution.

Complaints that do not rise to this level of severity will be handled by the Department depending on the nature of the complaint. The parent/legal guardian of the child are informed that filing a grievance or making a complaint is not a pre-requisite or substitute for a fair hearing, and explains the difference between complaints and issues involving fair hearings.

If the complaint is about the provider, the participant will be asked to contact the provider directly. If they are unable to do so, Department staff will intervene and determine how to proceed within a 30 day period on a case by case basis. The Department may contact the agency on behalf of the complainant, or if the complainant does not want to be identified, the Department will follow up in a different manner. The Department will follow up with the agency and document the complaint and outcome in the complaint/critical incident database. If this is a reoccurring incident, it will be reported to the QA management team for further action to be taken.

If the complaint is around dissatisfaction with the participant's case manager, the Division of Family and Community Services management team will investigate the complaint within a 30 day period. If the complaint is substantiated the case manager's supervisor will be notified to address the concern with the case manager and complete additional training as needed to address the complaint. Depending on the level of severity of the substantiated complaint the management team will decide if further action is required.

If the complaint is around dissatisfaction with the Department's contractor the contract monitor will be notified and will investigate the complaint within a 30 day period. The contract monitor will report to the outcome to the Department Quality management team. At that time the QA management team will decide if further action is required.

Notes will be entered into the participant file or the provider file as appropriate. Billing issues will be referred to the Medicaid Management Information System (MMIS) representative in the region. They make notes on the MMIS system. Idaho's MMIS contractor uses a call escalation process to refer calls. They internally escalate displeased callers to the supervisor or manager and if the caller is still displeased, then the supervisor or manager refers the call to the Department's Medicaid Systems Support Team (MSST). If the call is regarding potential program abuse or possible fraud in a provider's billing, then the call is referred to the Department's Program Integrity Unit and/or the

Division of Licensing and Certification.

Timelines will vary with the nature of the complaint. If there is a complaint related to the health and safety of the participant, it will be handled immediately. Complaints that are not urgent will be handled within 30 days.

In addition, the Department conducts retrospective children's service outcome reviews with a statistically valid sample of waiver participants. Participant satisfaction with services and service providers is assessed and tracked in these reviews.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (complete Items b through e)
- No. This Appendix does not apply** (do not complete Items b through e)
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department requires that providers and other individuals responsible for monitoring the approved plan of service immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Department, the child protection authority, or any other entity identified under Section 16-1605, Idaho Code which includes: The proper law enforcement agency or the department. The department shall be informed by law enforcement of any report made directly to it. When the attendance of a physician, resident, intern, nurse, day care worker, or social worker is pursuant to the performance of services as a member of the staff of a hospital or similar institution, he shall notify the person in charge of the institution or his designated delegate who shall make the necessary reports.

The Department requires reporting for the following types of critical incidents:

- Abuse - The intentional or negligent infliction of physical pain, injury or mental injury (Idaho Code, 39-5302(1))
- Exploitation - An action which may include, but is not limited to, the misuse of a vulnerable person's funds, property, or resources by another person for profit or advantage (Idaho Code, 39-5302 (7))
- Suspicious death of a participant - A death is labeled as suspicious when either a crime is involved, accident has occurred, the death is not from an expected medical prognosis, a participant dies unexpectedly under care, or when a participant's death occurs because of trauma in a medical setting
- Hospitalizations - when a participant is hospitalized as a direct result of an incident by a paid provider (medication error, physical injury, quality of care, neglect, treatment omission, or failure to follow established plans of care)
- Injury Caused by Restraints - an injury to a participant is caused by any of the following restraints: 1) Physical restraint is any manual method or physical or manual device, material or equipment attached or adjacent to the participant's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body; 2) Chemical restraint is any drug that is used for discipline or convenience and not required to treat medical symptoms:
 - Discipline - any action taken by the provider for the purpose of punishing or penalizing participants
 - Convenience - any action taken by the provider to control a participant's behavior or manage a participant's behavior with a lesser amount of effort by the provider and not in the participant's best interest

- Medical symptom - an indication or characteristic of a physical or psychological condition
- Medication error - any type of medication related mistake that deviates from the prescription that may negatively impact a participant's health or cause him/her serious injury
- Neglect - failure of a caretaker to provide food, clothing, shelter or medical care reasonably necessary to sustain life and health of a vulnerable adult or child, or the failure of a vulnerable adult to provide those services to him/herself (Idaho Code 39-5302(8))
- Child is the victim of a crime - a participant who suffers harm as a direct result of an act committed, or allegedly committed, by another person in the course of a criminal offense. Harm means the participant suffered actual physical harm, mental injury, or the participant's property was deliberately taken, destroyed or damaged
- Safety - the participant is placed in a position of danger and risk either intentionally or unintentionally
- Serious injury - an injury that requires professional medical treatment, e.g. hospitalizations, fractures, and wounds requiring stitches

Reports to the Department may be made by phone, mail, fax, email, or in person. The Department tracks reports through a Complaint/Incident Reporting Application.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At the time of initial eligibility determination, all participants receive information on participant rights and contact information for the Department.

During the annual eligibility process each family receives an "It's Your Right" document from the IAP. This document gives information on when a report should be made and how to make a report for abuse or neglect. In addition, the case manager provides education to the family during the annual family-centered planning process including advocacy organizations that they may contact if they have questions about their rights or want to file a complaint about a violation of rights.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Professionals and other persons identified in Section 16-1605, Idaho Code, have a responsibility to report abuse, neglect, or abandonment and are provided protection for reporters. All Department of Health and Welfare personnel are responsible for recognizing and immediately reporting to Child and Family Services or to law enforcement any concern regarding abuse, neglect, or abandonment of a child or children. Failure to report as required by Section 16-1605, Idaho Code, is a misdemeanor. (IDAPA 16.06.01.551 Reporting Abuse Neglect, or Abandonment). Professionals must report the State's defined critical incidents within 24 hours.

All other reports that come to the Department are followed-up on by the Department. All complaints or critical incidents are entered into the Complaint/Critical Incident Reporting Application. Reports that cannot be immediately resolved by the initial point of contact person are prioritized depending on the nature of the report.

A complaint or critical incident always requires a documented response to the person submitting the complaint/critical incident. The mode and content of the reply depends on the nature or complexity of the complaint/critical incident.

The complaint/critical incident must be investigated within a 30 day period.

Response Time Frames

Complaint/critical incidents require a timely response. Guidelines for response times for a complaint/critical incident are based on two (2) priority levels:

Priority One -

There is an immediate health or safety issue:

Idaho Code requires that complaints or reports of abuse, neglect or exploitation must be reported immediately to Child Protection and to the appropriate law enforcement agency within four (4) hours. The Department continues to collaborate as needed with the child protection agency after making a referral. A report of any other complaint or critical incident that may impact the health and/or safety of a child must be responded to as appropriate to assure the health and safety of the child.

A complaint or incident of this nature may result in an interim resolution/response until a permanent resolution/response can be accomplished, and the appropriate parties must be notified either by phone or a follow-up letter of the actions taken and results of the investigation.

Priority Two -

There is not an immediate health or safety issue:

The Department will follow Department Customer Service Standards for response times on phone calls, letters, and other communications. The resolution or status of the investigation must be communicated to the submitter within 10 business days.

At any time in the process of addressing a complaint/critical incident, the Director or Administrator may assign priority levels different from those defined above.

The Department assures that staff adhere to these timelines. Review of statewide compliance with priority timelines is assessed at least quarterly during the QA quarterly meetings.

Upon resolving the complaint, the assigned staff person or Unit will complete all documentation, notify appropriate agencies and participants, and notify the Department's DD Program Manager of the results and findings.

Additionally:

- a. When corrective actions are required, the DD Program Manager will notify, if applicable, the Division of Medicaid Deputy Administrator, Regional Director, Licensing and Certification, Medicaid Program Integrity unit, and/or the Deputy Attorney General of investigation findings and recommended resolution.
- b. The DD Program Manager may require that the investigating staff person or Unit expand the investigation or take additional action.

Complaint/critical incidents will be processed in a timely manner, and all written communication must be reviewed by a program supervisor or designee(s) prior to mailing the results to the submitter.

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department of Health and Welfare is responsible for all reports of critical incidents that affect waiver participants. The status and resolution of each report is available in the Complaint/Critical Incident Reporting Application.

All complaints and critical incidents are managed through a Complaint and Critical Incident database. On a monthly basis, a statewide team performs reviews to assure that reports and investigations are timely and accurately documented. Also the team, on a quarterly basis, compiles and reports regarding all children's DD related complaints and critical incidents to be analyzed. The children DD program manager tracks this data in the complaint/critical incident database and compiles quarterly reports for the QA committee to review. Through this review the committee identifies issues and works to make improvements to the system.

Annually, all complaint and critical incidents are analyzed and trended and prepared in a report for the Division. On a monthly basis, administration meets to review waiver and regionally based programs and activities, and dedicates part of its agenda to Quality Management. Each report details Quality Management related activities and reports Complaint and Critical Incidents and trends to the administration team.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

- The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

- **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Participant's rights regarding use of restraints are provided under Sections 66-412 and 66-413, Idaho Code.

No restraints, other than physical restraint in an emergency, are allowed prior to the use of positive behavior interventions. The use of restrictive interventions must be determined, agreed to, and documented through the person-centered planning process. The following restraints may be used under these circumstances:

Chemical Restraint: The use of any medication that results or is intended to result in the modification of behavior. Chemical restraint is only allowed when authorized by the attending physician.

Mechanical Restraint: Any device that the participant cannot remove easily that restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body or environment. Excluded are devices used to achieve proper body position, balance, or alignment. Mechanical restraint may only be used when necessary for the safety of the participant or for the safety of others and only when authorized by the attending physician.

Physical Restraint: Any device or physical force that restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body except for treatment of a medical condition. Non-emergency physical restraint and seclusionary time out may be used only when a behavior implementation plan is developed. A seclusionary time out is the contingent removal of an individual from a setting in which reinforcement is occurring that is designed to result in a decrease in the rate, intensity, duration or probability of the occurrence of a response, and entails the removal of the individual to an isolated setting.

If an HCBS setting quality poses a health or safety risk to the participant or those around the participant, goals must be identified with strategies to mitigate the risk. These goals and strategies must be documented in the person-centered plan. If a strategy included a restrictive intervention, the restrictive intervention applied is unique to each individual and is based on their specific needs. Risk mitigation strategies and exceptions are determined through the person-centered planning process and agreed to by the participant and/or guardian.

Setting qualities that may warrant risk mitigation include:

- Full integration and access to the community, including:
 - Freedom to control personal resources
 - Freedom to work in competitive integrated settings
 - Freedom to engage in community life
 - Freedom to receive services in the community
 - Right to privacy
 - Autonomy in making choices, including daily activities, physical environment, and with whom to interact
- Opportunities for choice regarding services and supports

Setting qualities that may warrant an exception include:

- Freedom and support to control schedules and activities
- Access to food
- Ability to have visitors at any time
- Physically accessible setting

A behavior implementation plan must be developed by the participant, the parent/legal guardian, the family-centered planning team, and a therapeutic consultant or psychologist. Written informed consent is required for all use of restraints.

Personnel involved with administering restraints must, at a minimum meet the provider qualifications of a habilitative interventionist as defined in Appendix C.

The Department uses the following methods to detect unauthorized use of restraints:

- Department plan monitoring completed at least every 6 months.
- Received complaints on an ongoing basis.
- Children Service Outcome Reviews, which are performed annually on a sample of families.
- Agency audits which occur at least every three years for each agency.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of Health & Welfare is responsible for overseeing the use of restraints.

The Department reviews all plans of service prior to the implementation of the plan. If a child's person-centered planning team believes the participant may require a restrictive intervention to be maintained safely in the community, the plan must outline how:

- 1) Positive interventions will be used prior to restraint
- 2) Restraint will be used
- 3) Provide documentation that the appropriate authority (as outlined above) has reviewed and approved the use of restraints.

The Department assures that these requirements have been met prior to approval and authorization of the plan. The plan of service is reviewed at least every 6 months by the Department, or more frequently as necessary depending on the type of restraint, to monitor the services provided. If all of these assurances have not been met, the proposed plan of service is not authorized.

The Department also reviews all complaints received regarding inappropriate use of restraints. If providers are discovered using restraint without approval, they are referred to the appropriate authority (child protection, adult protection or law enforcement) and have appropriate action taken against their certification and provider agreement. Depending on the seriousness of the violation, action may be anything from a required plan of correction to termination of provider agreement.

The Department conducts children service outcome reviews (CSOR) on an annual basis. The Department samples a group of children accessing waiver services and performs a file review, conducts satisfaction reviews with the parent or legal guardian and participant, and observes while the child is receiving services. Through this process if the Department discovers areas of concern the Department will escalate issues to the enhanced review process, which is a more in depth investigative process. If specific problems are identified the Department will make a referral to the appropriate authorities for appropriate action to be taken. This action may be a required plan of correction, termination of authorization for the service, termination of the provider agreement or termination of their certification, depending on the seriousness of the violation.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

- b. **Use of Restrictive Interventions.** *(Select one):*

- The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions

and how this oversight is conducted and its frequency:

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Effective July 1, 2016, the only restrictive interventions that may be implemented by a children's DD waiver provider include risk mitigation strategies and exceptions related to the HCBS setting qualities described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," that are in place to ensure the health and safety of the participant. not permit the use of aversive methods to modify behavior.

All service plans must include an assessment of any risks that may interfere with the participant's needs being met, in addition to potential health and safety risks with a corresponding back-up plan to ensure those risks are addressed. In the event of a health and safety risk that is associated with an HCBS setting requirement, the service plan must also reflect any corresponding risk mitigation strategies in place that are appropriate to the individual's assessed need(s) and that individual has provided informed consent.

Restrictive interventions may only be used when it is documented that they represent the least-restrictive environment for the participant to live safely and effectively in the community. In addition, positive behavior interventions must be used prior to and in conjunction with, the implementation of any restrictive intervention. All restrictive interventions must be included in the Action Plan and implementation plans and must be developed with involvement from the participant, the parent/legal guardian, the family-centered planning team, and a therapeutic consultant or psychologist.

When the program contains restrictive components, the therapeutic consultant or psychologist must review and approve, in writing, the plan prior to implementation. The TCM and parent or legal guardian must also be notified and agree to the restrictive intervention prior to implementation.

The Department must approve restrictive procedures, and the therapeutic consultant or psychologist must develop a plan for implementing the restrictive procedure that includes the type of procedure and frequency and duration. This plan is monitored by the consultant and the Department to ensure the procedure is being delivered appropriately.

Personnel involved with administering restraints or seclusion must, at a minimum meet the provider qualifications of a habilitative interventionist as defined in Appendix C.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Health & Welfare is responsible for monitoring and overseeing the use of restrictive interventions.

The Department reviews all plans of service prior to the implementation of the plan. If the person-centered planning team believes the participant may require a restrictive intervention, the plan must detail how positive behavior interventions will be used prior to, and in conjunction with, the implementation of any restrictive intervention. In addition there must be documentation that the participant, the parent/legal guardian, the person-centered planning team and any other interested parties were involved in the decision-making process and agree that this represents the least-restrictive environment for the participant.

The Department assures that these requirements have been met prior to approval and authorization of the plan. If all of these assurances have not been met, the proposed plan of services is not authorized.

The Department also reviews all complaints received regarding violations of participant rights, including inappropriate use of restrictive interventions. If the case manager discovers a provider using restrictive

interventions that are not approved on the Plan of Service, appropriate action is taken. This action is typically a required plan of correction but may be more serious depending on the specific violation and the provider's history. If a provider believes there is misuse of interventions, the provider must ensure the child's health and safety is not at risk and should report it to the Department.

The Department conducts children service outcome reviews (CSOR) on an annual basis. The Department samples a group of children accessing waiver services and performs a file review, conducts satisfaction reviews with the parent or legal guardian and participant, and observes while the child is receiving services. Through this process the Department discovers areas of concern and will escalate issues to the enhanced review process, which is a more in depth investigative process. Specific problems are identified and referred to the appropriate authorities for appropriate action to be taken. This action may be a required plan of correction, termination of authorization for the service, termination of the provider agreement or termination of their certification, depending on the seriousness of the violation.

Regional QA/QI staff will also monitor the use of risk mitigation strategies and exceptions during provider quality reviews. During these reviews, a sample of service plans is examined. Provider quality reviews will include an assessment of appropriate documentation of risk mitigation strategies and participant consent.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

- The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.
- i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Effective July 1, 2016, the only restrictive interventions that may be implemented by a children's DD waiver provider include risk mitigation strategies and exceptions related to the HCBS setting qualities described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," that are in place to ensure the health and safety of the participant. The use of seclusion must be determined, agreed to, and documented through the person-centered planning process.

All service plans must include an assessment of any risks that may interfere with the participant's needs being met, in addition to potential health and safety risks with a corresponding back-up plan to ensure those risks are addressed. In the event of a health and safety risk that is associated with an HCBS setting requirement, the service plan must also reflect any corresponding risk mitigation strategies in place that are appropriate to the individual's assessed need(s) and that individual has provided informed consent.

Participant's rights regarding use of seclusion are provided under Section 66-412, Idaho Code.

Non-emergency seclusionary time out may be used only when a behavior implementation plan is developed. A seclusionary time out is the contingent removal of an individual from a setting in which reinforcement is occurring that is designed to result in a decrease in the rate, intensity, duration or probability of the occurrence of a response, and entails the removal of the individual to an isolated

setting.

A behavior implementation plan must be developed by the participant, the parent/legal guardian, the family-centered planning team, and a therapeutic consultant or psychologist. Written informed consent is required for all use of seclusionary time outs.

Personnel involved with administering seclusion must, at a minimum meet the provider qualifications of a habilitative interventionist as defined in Appendix C.

The Department uses the following methods to detect unauthorized use of restraints:

- Department plan monitoring completed at least every 6 months.
 - Received complaints on an ongoing basis.
 - Children Service Outcome Reviews, which are performed annually on a sample of families.
 - Agency audits which occur at least every three years for each agency.
- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of Health & Welfare is responsible for overseeing the use of seclusion.

The Department reviews all plans of service prior to the implementation of the plan. When a provider believes the participant may require seclusion to be maintained safely in the community, the plan must outline how:

- 1) Positive interventions will be used prior to seclusion
- 2) Seclusion will be used
- 3) Provide documentation that the appropriate authority (as outlined above) has reviewed and approved the use of seclusion.

The Department assures that these requirements have been met prior to approval and authorization of the plan. The plan of service is reviewed at least every 6 months by the Department, or more frequently as necessary depending on the type of seclusion, to monitor the services provided. If all of these assurances have not been met, the proposed plan of service is not authorized.

The Department also reviews all complaints received regarding inappropriate use of seclusion. If providers are discovered using seclusion without approval, they are referred to the appropriate authority (child protection, adult protection or law enforcement) and have appropriate action taken against their certification and provider agreement. Depending on the seriousness of the violation, action may be anything from a required plan of correction to termination of provider agreement.

The Department conducts children service outcome reviews (CSOR) on an annual basis. The Department samples a group of children accessing waiver services and performs a file review, conducts satisfaction reviews with the parent or legal guardian and participant, and observes while the child is receiving services. Through this process if the Department discovers areas of concern the Department will escalate issues to the enhanced review process, which is a more in depth investigative process. If specific problems are identified the Department will make a referral to the appropriate authorities for appropriate action to be taken. This action may be a required plan of correction, termination of authorization for the service, termination of the provider agreement or termination of their certification, depending on the seriousness of the violation.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- No. This Appendix is not applicable** *(do not complete the remaining items)*
- Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards**Appendix G-3: Medication Management and Administration (2 of 2)****c. Medication Administration by Waiver Providers****Answers provided in G-3-a indicate you do not need to complete this section**

- i. Provider Administration of Medications.** *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- iii. Medication Error Reporting.** *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

- (a) Specify State agency (or agencies) to which errors are reported:

- (b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance: *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of reported instances of abuse, neglect, exploitation and unexplained death that were investigated. a. Numerator: Number of reported instances of abuse, neglect, exploitation and unexplained death that were investigated. b. Denominator: Number of reported instances of abuse, neglect, exploitation and unexplained death.

Data Source (Select one):
Critical events and incident reports
 If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

	<input type="text"/>
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Performance Measure:

Number and percent of participants and/or legal guardians who received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver. a.Numerator: Number of participants (and/or legal guardians) who received information/education about how to report. b.Denominator: Number of participants receiving waiver services.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number of substantiated instances of abuse, neglect, exploitation and unexplained death that were remediated. a. Numerator: Number of substantiated instances of abuse, neglect, exploitation and unexplained death that were remediated. b. Denominator: Number of substantiated instances of abuse, neglect, exploitation and unexplained death.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>		

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of all incidents investigated according to the state critical event or incident timeframes. a. Numerator: Number of incidents investigated according to the state critical event or incident timeframes. b. Denominator: Number of incidents investigated.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence

		Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of service plans with restrictive interventions (including restraints and seclusion) that were approved according to criteria. a. Numerator: Number of service plans with restrictive interventions that were approved according to criteria. b. Denominator: Number of service plans reviewed with restrictive interventions.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5% and a confidence level of 95%.
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- d. **Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of participants who received an annual wellness examination

a. Numerator: Number of participants who received an annual wellness examination. b. Denominator: Number of participants receiving waiver services.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 50px;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100px;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100px;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

		<input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
 If areas of concern are identified during the children’s service outcome review, an enhanced review is conducted for further investigation. This involves interviews with the participant, close family or friends, and the service provider.

If a service deficiency is found, a Plan of Correction (POC) is initiated by the Department and must be submitted by the provider within 10 days of initiation. The POC must include a response to each deficiency stating:

- What actions will be taken,
- Who will be responsible for the corrective action,
- How the corrective actions will be monitored to ensure consistent compliance with Idaho Code,
- Dates the corrective action will be completed, and
- What type of evidence of documentation will be provided to the Department documenting that the corrective action plan has been implemented.

QA staff will follow up with the agency within 45 days of the POC submission to assure that the plan for correction has been implemented. If the provider fails to implement the corrective action plan within a 45 day period the child’s authorization of services could be terminated with that specific provider. In addition, depending on the lack of compliance the Department may immediately terminate the provider agreement. The QA staff could make a referral to Medicaid Integrity Program Unit, and if the service deficiency affects a provider who is certified the operating team would refer the provider to the Division of Licensing and Certification.

If the review reveals issues that potentially put the participant’s health and safety at risk, mandatory reporting laws must be followed, and the incidents must be recorded in the critical incident/complaint database.

System Data Review involves obtaining data for indicators not specific to the participant outcome review, including provider requirements and contract monitoring. The data for these indicators are collected through monthly, quarterly and annual reports and reviews.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Department has developed the following process for trending, prioritizing, and implementing system improvements that have been prompted as a result of data analysis:

- 1) Weekly - The Quality Management Team is a group of FACS Quality Assurance (QA) staff, who are responsible for collecting and reporting data to the central office Quality Management Data Analyst. QA staff

are primarily responsible for gathering CSOR results, investigating complaint and critical incident reports, and reviewing Action Plans.

2) Monthly - The FACS Quality Management Data Analyst is identified as the specialist and lead for statewide data collection activities, analysis, and reporting activities related to quality management. This position is primarily responsible for creating and implementing data collection tools. Specifically, the FACS QM Data Analyst reviews, analyzes and tabulates CSOR results, complaints and critical incidents, and Action Plan information.

3) Quarterly - The Department has established a Quality Management (QM) Committee responsible for steering the quality assessment and improvement process and issues related to parallel data collection. The QM Committee meet on a quarterly basis. The QM Committee is primarily responsible for formally recommending specific program improvements to Department Administration. FACS policy program manager is responsible for leading team members and the QM committee, finalizing the quarterly reports, leading the process of prioritizing needs for system improvements, and implementing approved system improvements.

4) Annually -The Quality Management committee meets annually upon completion of the annual QM report to prioritize findings and develop recommendations for specific system improvements for the coming year. This recommendation is submitted to administration for approval and assignment. FACS policy program manager is responsible for finalizing the annual reports. Within the first quarter of the waiver year, FACS policy program manager will calculate the participant sample size to identify the participant's for the CSOR using a simple random sampling method, combining both Idaho children's waivers at 95% confidence level and +/- 5% margin of error.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Department has developed the following process for monitoring and analyzing the effectiveness of system design changes:

- 1)The FACS Quality Management Team collects data and investigates complaints and incidents on an ongoing basis and submits this information to the FACS QM Data Analyst for review.
- 2) The Medicaid Quality Management Manager monitors and reports quarterly on unduplicated participants for children receiving waiver services.
- 3) The FACS Data Analyst presents the data findings to the Quality Management Committee for review and prioritization.
- 4) The QM Committee meets on a quarterly basis to review the analyzed data in order to develop

recommendations for program improvements, and review actions taken and progress made toward implementing previous approved system improvements. This quarterly progress is reported to administration.

5) The QM Committee submits the overall data findings and recommendations to the FACS policy program manager for review prior to finalization.

When remediation is identified and cannot be agreed upon during the quarterly QA committee meetings, the Division of Medicaid's Bureau Chief and the Division of FACS Bureau Chief will present the issues to the Medicaid and FACS Administrators. If the issue still cannot be agreed upon the Administrators will present the issue to Medicaid's Deputy Director and FACS Deputy Director. If at that time there is no decision that is agreed upon the Deputy Directors will present the issue to the Director of the Department of Health and Welfare who will make the final decision.

There are several methods the Department uses to communicate policy changes and other important updates to the public. Information releases (IR) are issued to providers and/or participants to update them on policy, billing, or processing changes. IRs are often sent out to a specific group of providers or participants who may be directly impacted by any changes.

The Department also posts a Medicaid newsletter on the Department of Health and Welfare's website. The Medicaid newsletter is a monthly publication that communicates information to Medicaid providers and other interested parties, and incorporates any IRs that were issued the previous month.

In addition, state law requires that the public receive notification when a state agency initiates proposed rulemaking procedures and be given an opportunity to comment to that rulemaking. Notification of a proposed rulemaking is provided through a Legal Notice that publishes in local newspapers and the Department's website whenever a proposed rulemaking is being published in the Bulletin.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Department is consistently evaluating and improving processes and systems on an ongoing basis. Each year the Department improves services to waiver clients by using numerous data collection points, appropriate analysis and prioritization techniques, evaluation and feedback from differing groups.

The Department identified a need for a more coordinated approach to quality assurance in the Department and as a result has formed a quality assurance policy committee that has developed a global quality improvement strategy and management plan. This committee convenes on an ongoing basis to assure that the global QIS continues to provide the following benefits for Idaho Developmental Disabilities (ID. 0076), Aged and Disabled (ID. 1076), childrenTMs DD (ID. 0859), and Act Early (ID.0887) 1915c waivers and 1915i state plan benefits in Idaho:

- Remediation can be tracked by Waiver and across multiple Waivers
- Data can be aggregated and analyzed across multiple Waivers
- Systems improvements can be developed to benefit all participants across multiple Waivers
- Effective and efficient way to monitor compliance with sub-assurances across multiple Waivers
- Strengthens oversight by an agency operating several Waivers
- Strengthens oversight of the Medicaid agency in concert with the operating agency

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a)The Department must authorize all services reimbursed by Medicaid under the HCBS Waiver Program before the services are rendered. Prior authorizations for approved services are entered into the Medicaid Management Information System (MMIS) by the Department. The prior authorization number must appear on the claim or it will be

denied. Approved prior authorizations are valid for one (1) year from the date of prior authorization by the Department unless otherwise indicated. Claims are adjudicated by the MMIS in accordance with Federal guidelines and Idaho policies. This includes extensive claim edit and audit processing, claim pricing, and claim suspense resolution processing.

b)The Surveillance and Utilization Review processes support the post-payment analysis of expenditures to identify potential misuse, abuse, quality of care, and treatment outcomes in Medicaid. Functions specifically supported by these processes include the traditional surveillance and utilization review (SUR) features of the MMIS and outcome-oriented analysis regarding quality of care assessments.

The Department conducts performance monitoring of the MMIS contract to ensure that claims are adjudicated by the MMIS in accordance with Federal guidelines and Idaho Policies.

All records are maintained by the MMIS and are available for review during post-payment audits. These records include: all claims submitted either electronically or on paper, all remittance and status reports which accompany provider payments; and all adjustment request forms.

c)The State requires the MMIS contractor to contract with, and pay for an independent certified public accounting firm to perform an annual audit of the contractor's services to the State in compliance with AICPA Statement on Auditing Standards number 70 (Reports on the Processing of Transactions by Service Organizations).

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of claims paid according to the posted fee schedule.

a.Numerator: Number of claims paid according to the posted fee schedule.

b.Denominator: Paid claims (by procedure code) for one week of each calendar quarter.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Ad-Hoc paid clams report

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of service delivery records reviewed that support claims paid for waiver services. Numerator: Number of service delivery records reviewed that support claims paid for waiver services. Denominator: Number of claims billed for waiver services in the sample.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%, Confidence Level = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually

<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of posted rates that are consistent with the approved waiver rate methodologies. a.Numerator: Number of posted rates (by procedure code) that are consistent with the approved waiver rate methodology. b.Denominator: Number of procedure codes derived from rate methodologies in the approved waiver.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Bureau of Financial Operations financial report

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

		<input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
 If a deficiency is found during a review of the financial reports, a request for a Plan of Correction (POC) is initiated by the Department and the provider must submit the POC within ten (10) days of the written notice. In addition, a referral to the Medicaid Program Integrity Unit will be initiated. The POC must include a response to each deficiency stating:
 - What actions will be taken,
 - Who will be responsible for the corrective action,
 - How the corrective actions will be monitored to ensure consistent compliance with Idaho Code,
 - Dates the corrective action will be completed, and
 - What type of evidence of documentation will be provided to the Department documenting that the corrective action plan has been implemented.

- ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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).

Pursuant to 42 CFR § 447.205, the Idaho Department of Health and Welfare 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.

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 holds hearings when we promulgate rules to describe the reimbursement methodology.

Please see below for services and Reimbursement Methodology information:

Respite:

Individual and Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Respite Individual/Group, we use the Bureau of Labor statistics (BLS) mean wage (Idaho) for all others (BLS code 39-9099) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using Global Insights Mountain States Market Basket (GI) inflation index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and

general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS Mountain West Division's (MWD) report. The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Habilitative Supports:

Individual and Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Habilitative Supports Individual/Group, we use the (BLS) mean wage (Idaho) for all others (BLS code 31-9099) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report. The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Habilitative Intervention:

Individual and Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Habilitative Intervention Individual/Group, we use the Bureau of Labor statistics (BLS) mean wage (Idaho) for all others (BLS code 29-1129) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report. The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Therapeutic Consultation:

Individual- The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Therapeutic Consultation Individual, we use the Bureau of Labor statistics (BLS) mean wage (Idaho) for all others (BLS code 29-9099) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report. The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Family Education:

Individual and Group - The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Family Education Individual/Group, we use the (BLS) mean wage (Idaho) for all others (BLS code 29-1129) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report. The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current

DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Family Training:

Individual-The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Family Training Individual, we use the (BLS) mean wage (Idaho) for all others (BLS code 29-9099) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report. The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Crisis Intervention-Professional/Technician:

The reimbursement methodology adds many cost components together to arrive at a 15 min unit rate for the Crisis Intervention-Professional/Technician; we use the (BLS) mean wage (Idaho) for all others (BLS code 29-9099) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report. The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a quarterly unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Interdisciplinary Training:

Individual- The reimbursement methodology adds many cost components together to arrive at a 30 min unit rate for Interdisciplinary Training Individual, we use the Bureau of Labor statistics (BLS) mean wage (Idaho) for all others (BLS code 29-1129) which uses reasonable payroll rate studies. Then, this hourly wage is inflated by using (GI) index. In SFY 2010 (2 months) it was .0005% and SFY 2011 it is .008%. Using the Survey results we use direct care staff multipliers for employer related, program related, and general & administrative percentages. These multipliers are decreased to accommodate the average payroll rate currently paid for these services along with the BLS cost for employer related payroll expenses. Lastly, we add costs for paid leave time for direct care staff based on BLS (MWD) report.

The dollar figure arriving from the calculations is divided by the ratio provided. The hourly rate then is brought into a half unit rate, or the target rate. The final unit rate is 84.73% of the target rate. We are using the most current DD/MH rates dictated by Idaho code 56-118 and used to calculate the 84.73% adjusted target rate.

Financial Management Services -Reimbursement methodology for FMS is based on a market study of other state Medicaid program rates for FMS to gather a range which allows the Department to accept a fee for service rate within the range determined from the market study. The established payment rates for each department approved qualified FMS provider will be published on a fee schedule by the Department. This fee schedule will be updated as needed. This information will be published for consumer convenience to the IDHW Medicaid website.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Traditional DD waiver provider billing flows directly from the provider to the State's claim payment system, Idaho Medicaid's Management Information System (MMIS).

Participants who choose to family-direct their services and supports use a Fiscal Employer Agent to process provider billing. The Fiscal Employer Agent pays claims that have been approved on the plan and then bills the MMIS.

Appendix I: Financial Accountability

I-2: RATES, BILLING AND CLAIMS (3 of 3)

c. Certifying Public Expenditures (select one):

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

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

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All Medicaid claims for waiver services are processed through the State's Medicaid Management Information System (MMIS). The MMIS is managed and monitored through the Department.

Participant eligibility for Medicaid is determined by the Division of Welfare. Participant eligibility for waiver services is determined by the IAP. Once eligibility for waiver services is determined, the participant's information and eligibility is electronically transmitted to the MMIS from the State's Idaho Benefits Eligibility System (IBES). Claims are edited, which includes the date of service, against the eligibility file in the MMIS to ensure that claims are paid for Medicaid eligible participants only.

Prior authorization of Medicaid reimbursable services on the approved plan of service is entered into the MMIS and is used in the claims adjudication process by the Department.

Explanation of Medicaid Benefits are generated monthly and sent to a sampling of participants receiving services to verify that the services were provided. The sample size of participants that receive an Explanation of Benefits notice is 1% of the eligible participants that had paid claims in the past months. The Department's Program Integrity Unit opens two to three cases per month based on participant responses to this auditing process. In addition, the Program Integrity Unit uses a utilization review system that categorizes all providers by type and specialty, ranks them in categories, and does a peer grouping analysis comparing provider billing patterns against their peers. It ranks the most probable

abusive patterns from most to least abusive. Providers with probable abusive billing patterns receive further analysis by Program Integrity Unit staff and follow-up reviews are initiated when warranted. Finally, during the Children's service outcome reviews, Department staff review participant progress notes and documentation of services. When staff discover inadequate documentation or inconsistent service delivery, they make a referral to the Program Integrity Unit for further investigation.

All records are maintained by the MMIS and are available for review during post-payment audits. These records include: all claims submitted either electronically or on paper, all remittance and status reports which accompany provider payments, all member eligibility records, and all adjustment request forms.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. **Method of payments -- MMIS** (*select one*):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Family-Directed Services are paid through a qualified financial management service provider chosen by the participant. The financial management service provider then bills Medicaid through the MMIS as prior authorized by the Department. The financial management service provider chosen by the participant maintains records for each participant that indicate spending of the approved individualized budget within the following categories: 1) Support Broker Services; 2) Community Support Services, 2a) Job Support, 2b) Personal Support 2c) Relationship Support, 2d) Emotional Support, 2e) Learning Support, 2f) Transportation Support, and 2g) Adaptive Equipment.

The Department enters into a provider agreement with qualified Financial Management Service providers to perform Financial Management Services for participants who choose to family-direct under the FDS option.

The Department monitors the financial activities of the qualified financial management service provider through quarterly financial audit and oversight activities through the following methods:

- Audits of transactions performed by the financial management service provider through selection of a random sample of participants and review of records and transactions that the financial management service provider has completed on behalf of those participants. The audit methodology will use statistically valid standards to assure that the sample is random and of sufficient size to achieve statistical significance.
- Requiring that the financial management service providers ensure the quality of the services performed on behalf of all participants for who they provide Financial Management Services and reviewing the results of these internal quality assurance activities.
- Assessment of participant satisfaction with the services provided by qualified financial management service providers as part of the participant experience survey.

In addition to these quarterly financial oversight activities, the Department will issue an annual formal report and assessment of the financial audit findings to each FMS provider which will include the results of the combined quarterly financial assessments completed over the course of the year.

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

The Infant Toddler program is qualified to provide the following waiver services: respite, habilitative supports, family education, habilitative intervention, family training, crisis intervention, Interdisciplinary Training, and therapeutic consultation.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

- e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

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:

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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.

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- 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.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

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- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

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Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the

individual.

- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.
- b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The only waiver service that has the opportunity of being provided in a residential setting other than the personal home is respite care. Payments for respite care is based solely on service costs and do not include the cost of room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
 - i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

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Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	12103.63	18971.00	31074.63	91626.00	7577.00	99203.00	68128.37
2	12537.92	19920.00	32457.92	93125.00	7956.00	101081.00	68623.08
3	13166.42	20916.00	34082.42	94625.00	8354.00	102979.00	68896.58
4	13828.63	21962.00	35790.63	96124.00	8772.00	104896.00	69105.37
5	14529.36	23060.00	37589.36	97624.00	9210.00	106834.00	69244.64

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	2277		2277
Year 2	2329		2329
Year 3	2380		2380
Year 4	2432		2432
Year 5	2483		2483

Appendix J: Cost Neutrality Demonstration

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

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The State of Idaho utilized the data from the children's DD services since the beginning of the waiver to identify an average length of stay. Idaho has questioned the accuracy of this data due to the inability of requiring children to transition to the waiver until July 1, 2013. At this time we have less than a year of actual data that identifies all participants in the program to utilize for this renewal.

REVISE: To estimate the waiver length of stay, the A&D waiver CMS 372 reports for the previous three years were used. Days are limited to 365.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Historical Medicaid expenditures for participants age 0-17 receiving developmental disabilities (DD) services from the internal MMIS system were analyzed from claims data from July 2009 to June 2013. Information based on the current system was used to determine access and utilization estimates of the new waiver services. These data estimates were then projected out over the five year estimate period based on the historical trend of children's DD services.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates were derived from actual data available in the internal MMIS system for children receiving DD services and then projected out over the five year estimate period based on the historical trend from claims data from July 2009 to June 2013. The state did not include the cost of prescribed drugs furnished to Medicare/Medicaid dual eligibles under the provision of Part D.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates were derived from actual data available in the internal MMIS system from claims data July 2009 to June 2013 based on Idaho's ICF/ID facilities. These were then projected out over the five year estimate period based on the historical trend.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates were derived from actual data available in the internal MMIS system from claims data from July 2009 to June 2013 and then projected out over the five year estimate period based on the historical trend.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Family Education
Habilitative Supports
Respite
Community Support Services
Financial Management Services
Support Broker Services
Crisis Intervention
Family Training
Habilitative Intervention
Interdisciplinary Training
Therapeutic Consultation

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). 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. If applicable, check the capitation box next to that service. 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 1

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Education Total:							45118.08
Family Education	<input type="checkbox"/>	15 min.	84	48.00	11.19	45118.08	
Habilitative Supports Total:							12824030.27
Habilitative Supports	<input type="checkbox"/>	15 min.	1627	1567.00	5.03	12824030.27	
Respite Total:							1363250.00
Respite	<input type="checkbox"/>	15 min.	665	1025.00	2.00	1363250.00	
Community Support Services Total:							3851016.46
Learning Support	<input type="checkbox"/>	week	191	52.00	102.43	1017334.76	
Transportation Support	<input type="checkbox"/>	week	125	52.00	24.23	157495.00	
Emotional Support	<input type="checkbox"/>	week	83	52.00	31.10	134227.60	
Personal Support	<input type="checkbox"/>	week	324	52.00	91.47	1541086.56	
Relationship Support	<input type="checkbox"/>	week	141	52.00	33.72	247235.04	
Adaptive Equipment	<input type="checkbox"/>	week	165	10.00	456.75	753637.50	
Financial Management Services Total:							646197.60
Financial Management Services	<input type="checkbox"/>	month	380	12.00	141.71	646197.60	
Support Broker Services Total:							378000.00
Support Broker Services	<input type="checkbox"/>	month	300	12.00	105.00	378000.00	
Crisis Intervention Total:							20274.12
Crisis Intervention	<input type="checkbox"/>	15 min.	18	199.00	5.66	20274.12	
Family Training Total:							737656.92
Family Training	<input type="checkbox"/>	15 min.	1012	63.00	11.57	737656.92	
Habilitative Intervention Total:							7645872.52
Habilitative						7645872.52	

Intervention	<input type="checkbox"/>	15 min.	1012	653.00	11.57		
Interdisciplinary Training Total:							28813.20
Interdisciplinary Training	<input type="checkbox"/>	30 min.	130	6.00	36.94	28813.20	
Therapeutic Consultation Total:							19732.68
Therapeutic Consultation	<input type="checkbox"/>	15 min.	22	54.00	16.61	19732.68	
GRAND TOTAL:							27559961.85
Total: Services included in capitation:							27559961.85
Total: Services not included in capitation:							2277
Total Estimated Unduplicated Participants:							12103.63
Factor D (Divide total by number of participants):							12103.63
Services included in capitation:							12103.63
Services not included in capitation:							
Average Length of Stay on the Waiver:							325

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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 2

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Education Total:							50939.52
Family Education	<input type="checkbox"/>	15 min.	86	48.00	12.34	50939.52	
Habilitative Supports Total:							14085959.68
Habilitative Supports	<input type="checkbox"/>	15 min.	1664	1528.00	5.54	14085959.68	
Respite Total:							1540370.00
Respite	<input type="checkbox"/>	15 min.	680	1025.00	2.21	1540370.00	
Community Support Services Total:							3945233.50
Learning Support	<input type="checkbox"/>	week	195	52.00	73.93	749650.20	
Transportation Support	<input type="checkbox"/>	week	128	52.00	26.72	177848.32	
Emotional Support	<input type="checkbox"/>	week	85	52.00	34.30	151606.00	
Personal Support	<input type="checkbox"/>	week	331	52.00	100.88	1736346.56	
Relationship Support	<input type="checkbox"/>	week	144	52.00	37.19	278478.72	

Adaptive Equipment	<input type="checkbox"/>	week	169	10.00	503.73	851303.70	
Financial Management Services Total:							755576.64
Financial Management Services	<input type="checkbox"/>	Month	403	12.00	156.24	755576.64	
Support Broker Services Total:							426607.20
Support Broker Services	<input type="checkbox"/>	Month	307	12.00	115.80	426607.20	
Crisis Intervention Total:							9959.04
Crisis Intervention	<input type="checkbox"/>	15 min.	12	133.00	6.24	9959.04	
Family Training Total:							795037.32
Family Training	<input type="checkbox"/>	15 min.	989	63.00	12.76	795037.32	
Habilitative Intervention Total:							7548740.30
Habilitative Intervention	<input type="checkbox"/>	15 min.	989	601.00	12.70	7548740.30	
Interdisciplinary Training Total:							32494.56
Interdisciplinary Training	<input type="checkbox"/>	30 min.	133	6.00	40.72	32494.56	
Therapeutic Consultation Total:							9887.40
Therapeutic Consultation	<input type="checkbox"/>	15 min.	15	36.00	18.31	9887.40	
GRAND TOTAL:						29200805.16	
Total: Services included in capitation:							
Total: Services not included in capitation:						29200805.16	
Total Estimated Unduplicated Participants:						2329	
Factor D (Divide total by number of participants):						12537.92	
Services included in capitation:							
Services not included in capitation:						12537.92	
Average Length of Stay on the Waiver:						325	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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 3

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/Unit	Component Cost	Total Cost
Family Education Total:							54743.04
Family Education	<input type="checkbox"/>	15 min.	88	48.00	12.96	54743.04	
Habilitative Supports							

Total:							15126924.96
Habilitative Supports	<input type="checkbox"/>	15 min.	1701	1528.00	5.82	15126924.96	
Respite Total:							1652710.00
Respite	<input type="checkbox"/>	15 min.	695	1025.00	2.32	1652710.00	
Community Support Services Total:							4196253.08
Learning Support	<input type="checkbox"/>	week	199	52.00	77.63	803315.24	
Transportation Support	<input type="checkbox"/>	week	131	52.00	28.06	191144.72	
Emotional Support	<input type="checkbox"/>	week	87	52.00	36.01	162909.24	
Personal Support	<input type="checkbox"/>	week	338	52.00	105.93	1861825.68	
Relationship Support	<input type="checkbox"/>	week	147	52.00	39.05	298498.20	
Adaptive Equipment	<input type="checkbox"/>	week	170	10.00	516.80	878560.00	
Financial Management Services Total:							838623.60
Financial Management Services	<input type="checkbox"/>	Month	426	12.00	164.05	838623.60	
Support Broker Services Total:							458151.12
Support Broker Services	<input type="checkbox"/>	Month	314	12.00	121.59	458151.12	
Crisis Intervention Total:							10453.80
Crisis Intervention	<input type="checkbox"/>	15 min.	12	133.00	6.55	10453.80	
Family Training Total:							853486.20
Family Training	<input type="checkbox"/>	15 min.	1011	63.00	13.40	853486.20	
Habilitative Intervention Total:							8099454.63
Habilitative Intervention	<input type="checkbox"/>	15 min.	1011	601.00	13.33	8099454.63	
Interdisciplinary Training Total:							34892.16
Interdisciplinary Training	<input type="checkbox"/>	30 min.	136	6.00	42.76	34892.16	
Therapeutic Consultation Total:							10384.20
Therapeutic Consultation	<input type="checkbox"/>	15 min.	15	36.00	19.23	10384.20	
GRAND TOTAL:							31336076.79
Total: Services included in capitation:							
Total: Services not included in capitation:							31336076.79
Total Estimated Unduplicated Participants:							2380
Factor D (Divide total by number of participants):							13166.42
Services included in capitation:							
Services not included in capitation:							13166.42
Average Length of Stay on the Waiver:							325

Appendix J: Cost Neutrality Demonstration
J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). 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. If applicable, check the capitation box next to that service. 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 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Education Total:							58795.20
Family Education	<input type="checkbox"/>	15 min.	90	48.00	13.61	58795.20	
Habilitative Supports Total:							16226107.04
Habilitative Supports	<input type="checkbox"/>	15 min.	1738	1528.00	6.11	16226107.04	
Respite Total:							1768432.50
Respite	<input type="checkbox"/>	15 min.	710	1025.00	2.43	1768432.50	
Community Support Services Total:							4491651.52
Learning Support	<input type="checkbox"/>	week	203	52.00	81.46	859891.76	
Transportation Support	<input type="checkbox"/>	week	134	52.00	29.44	205137.92	
Emotional Support	<input type="checkbox"/>	week	89	52.00	37.78	174845.84	
Personal Support	<input type="checkbox"/>	week	345	52.00	111.15	1994031.00	
Relationship Support	<input type="checkbox"/>	week	150	52.00	40.97	319566.00	
Adaptive Equipment	<input type="checkbox"/>	week	173	10.00	542.30	938179.00	
Financial Management Services Total:							928083.00
Financial Management Services	<input type="checkbox"/>	Month	449	12.00	172.25	928083.00	
Support Broker Services Total:							491515.20
Support Broker Services	<input type="checkbox"/>	Month	321	12.00	127.60	491515.20	
Crisis Intervention Total:							10980.48
Crisis Intervention	<input type="checkbox"/>	15 min.	12	133.00	6.88	10980.48	
Family Training Total:							915661.53
Family Training	<input type="checkbox"/>	15 min.	1033	63.00	14.07	915661.53	
Habilitative Intervention Total:							8691662.00
Habilitative Intervention	<input type="checkbox"/>	15 min.	1033	601.00	14.00	8691662.00	
Interdisciplinary Training Total:							37446.60
Interdisciplinary Training	<input type="checkbox"/>	30 min.	139	6.00	44.90	37446.60	

Therapeutic Consultation Total:							10902.60
Therapeutic Consultation	<input type="checkbox"/>	15 min.	15	36.00	20.19	10902.60	
GRAND TOTAL:							33631237.67
Total: Services included in capitation:							
Total: Services not included in capitation:							33631237.67
Total Estimated Unduplicated Participants:							2432
Factor D (Divide total by number of participants):							13828.63
Services included in capitation:							
Services not included in capitation:							13828.63
Average Length of Stay on the Waiver:							325

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** 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. If applicable, check the capitation box next to that service. 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Education Total:							63104.64
Family Education	<input type="checkbox"/>	15 min.	92	48.00	14.29	63104.64	
Habilitative Supports Total:							17385202.00
Habilitative Supports	<input type="checkbox"/>	15 min.	1775	1528.00	6.41	17385202.00	
Respite Total:							1894968.75
Respite	<input type="checkbox"/>	15 min.	725	1025.00	2.55	1894968.75	
Community Support Services Total:							4815887.64
Learning Support	<input type="checkbox"/>	week	207	52.00	85.55	920860.20	
Transportation Support	<input type="checkbox"/>	week	137	52.00	30.92	220274.08	
Emotional Support	<input type="checkbox"/>	week	91	52.00	39.68	187765.76	
Personal Support	<input type="checkbox"/>	week	352	52.00	116.73	2136625.92	
Relationship Support	<input type="checkbox"/>	week	153	52.00	43.03	342346.68	
Adaptive Equipment	<input type="checkbox"/>	week	177	10.00	569.50	1008015.00	
Financial Management Services Total:							1024391.04
Financial Management Services	<input type="checkbox"/>	Month	472	12.00	180.86	1024391.04	

Support Broker Services Total:							527424.00
Support Broker Services	<input type="checkbox"/>	Month	328	12.00	134.00	527424.00	
Crisis Intervention Total:							11523.12
Crisis Intervention	<input type="checkbox"/>	15 min.	12	133.00	7.22	11523.12	
Family Training Total:							981688.05
Family Training	<input type="checkbox"/>	15 min.	1055	63.00	14.77	981688.05	
Habilitative Intervention Total:							9320608.50
Habilitative Intervention	<input type="checkbox"/>	15 min.	1055	601.00	14.70	9320608.50	
Interdisciplinary Training Total:							40163.28
Interdisciplinary Training	<input type="checkbox"/>	30 min.	142	6.00	47.14	40163.28	
Therapeutic Consultation Total:							11448.00
Therapeutic Consultation	<input type="checkbox"/>	15 min.	15	36.00	21.20	11448.00	
GRAND TOTAL:							36076409.02
Total: Services included in capitation:							
Total: Services not included in capitation:							36076409.02
Total Estimated Unduplicated Participants:							2483
Factor D (Divide total by number of participants):							14529.36
Services included in capitation:							
Services not included in capitation:							14529.36
Average Length of Stay on the Waiver:							325