NOTICE OF INTENT TO SUBMIT WAIVER AMENDMENTS
SOLICITATION OF PUBLIC INPUT
30-Day Comment Period

The purpose of this announcement is to provide notice that the Department intends to submit waiver amendments to the Centers for Medicare and Medicaid Services (CMS) for Idaho's Aged and Disabled 1915(c) Waiver, Adult Developmental Disabilities 1915(c) Waiver, Children's Developmental Disability 1915(c) Waiver and Act Early 1915(c) Waiver.

Idaho Medicaid is interested in receiving public input regarding the proposed waiver amendments.

HOW TO REVIEW THE WAIVER AMENDMENTS:

1) Visit the HCBS webpage at http://HCBS.dhw.idaho.gov to download the waiver(s) of interest to you. Look under the heading that says "What's New."
2) Use the "Index of Changes" that accompanies each waiver draft as your guide in identifying which sections were revised and the nature of those revisions. Remember, not all sections of the waivers reflect changes from the currently approved applications. It may be helpful to print the Index of Changes page(s) to facilitate your review of the waiver document.
3) You can easily identify the revised sections by looking for the headings or subheadings that are highlighted in yellow.

QUESTIONS

If you have questions regarding changes in the waiver application, you may contact the designated subject matter expert(s). Identify the appropriate person using the table below.

HOW TO SUBMIT COMMENTS:

Persons wishing to provide input may submit comments regarding one or more of the waivers. Identify the contact person for the waiver of interest to you from the table below. If you are providing comment(s) on more than one waiver, please indicate that as part of your comment.

Adult Developmental Disabilities Waiver	Children's Developmental Disabilities Waiver and Act Early Waiver	Aged and Disabled Waiver
Hand Deliver to: Medicaid Central Office Idaho Department of Health and Welfare 3232 W. Elder Street Attn: Stephanie Perry Boise, ID 83705 **Mail to:** PO Box 83720 Boise, ID 83720-0036 **FAX:** (208) 332-7286 **Email:** perrys@dhw.idaho.gov **Telephone:** (208) 364-1878	**Hand Deliver to**: Medicaid Central Office Idaho Department of Health and Welfare 3232 W. Elder Street Attn: Carolyn Burt Boise, ID 83705 **Mail to:** PO Box 83720 Boise, ID 83720-0036 **FAX:** (208) 332-7286 **Email:** burtc@dhw.idaho.gov **Telephone:** (208) 287-1174	**Hand Deliver to**: Medicaid Central Office Idaho Department of Health and Welfare 3232 W. Elder Street Attn: Ali Fernández Boise, ID 83705 **Mail to:** PO Box 83720 Boise, ID 83720-0036 **FAX:** (208) 332-7283 **Email:** fernanda@dhw.idaho.gov **Telephone:** (208) 287-1156

The Department will review all comments received prior to submitting the waiver amendments to the Centers for Medicare and Medicaid Services (CMS) for review. A summary document of the comments received in addition to the Department's response will be posted online once they have been reviewed and compiled.

Comments must be submitted to one of the above contact persons by **close of business on April 22, 2016**.

Act Early Waiver Amendment: Index of Changes

Section		Changes
Main	2. Brief Waiver Description	Include new IDAPA HCBS rules information
	6. Additional Requirements	Included recent public input activities.
	A. Attachment #2: HCBS Waiver Transition Plan	Include language regarding the status of Idaho's Statewide Transition Plan
Appendix A	Quality Improvement: Waiver Administration, a.	Update quality performance measure to align QA system and reflect new CMS requirements
Appendix B	Quality Improvement: Level of Care, a., b., c.	Update quality performance measure to align QA system and reflect new CMS requirements
Appendix C	1. Participant Services, Family Training	Adjust language from "must" to "should" per CMS regulation guidance. Include new taxonomies for each service category
	5. Home and Community-Based Settings	Insert description of settings, how they meeting HCBS settings requirements and how the state will ascertain that all waiver settings meet HCBS now and ongoing
	Quality Improvement: Participant Services, a., b., c	Update quality performance measure to align QA system and reflect new CMS requirements
Appendix D	1: Service Plan Development, c., d., e	Adjust language to include additional person centered planning requirements as outlined in 16.03.10
	Quality Improvement: Participant-Centered Planning, a., b., c.	Update quality performance measure to align QA system and reflect new CMS requirements
Appendix G	2. Safeguards Concerning Restraints, b., c.	Include language to include HCBS risk mitigation requirements
	Quality Improvement: Participant Safeguards, a., b., c., d	Update quality performance measure to align QA system and reflect new CMS requirements
Appendix I	Quality Improvement: Financial Accountability, a., b.	Update quality performance measure to align QA system and reflect new CMS requirements
ALL		Removed extraneous characters throughout the waiver application caused by CMS portal error

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:**
Act Early Waiver
C. **Waiver Number:ID.0887**
D. **Amendment Number:**
E. **Proposed Effective Date:** *(mm/dd/yy)*
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 purpose of this amendment to Idaho's Act Early Waiver is:

1. 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)
☑ **Waiver Application**	2. Brief Waiver Desc
☑ **Appendix A – Waiver Administration and Operation**	Quality Improvemen
☑ **Appendix B – Participant Access and Eligibility**	

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Component of the Approved Waiver	Subsection(s)
	Quality Improvemen
☑ Appendix C – Participant Services	1. Participant Service
☑ Appendix D – Participant Centered Service Planning and Delivery	1: Service Plan Deve
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☑ Appendix G – Participant Safeguards	2. Safeguards Concer
☐ Appendix H	
☑ Appendix I – Financial Accountability	Quality Improvemen
☐ 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*):
Act Early 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**

Draft ID: ID.009.01.03

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**

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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 in42 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:

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H. Dual Eligiblity 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, provides 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 Act Early waiver is to target the needs of children age 3-6 with Autism Spectrum diagnosis and/or maladaptive behaviors. Evidence-based research shows that young children with autism, or closely related conditions, will benefit from intensive, short-term intervention services. The Department wanted to create a benefit package in response to this research to ensure that children with developmental disabilities, in Idaho, get the right services at the right time. The program'™s key elements include an array of therapeutic interventions, support services, collaboration services and it places an emphasis on family participation during treatment.

The primary objective of the Children's Developmental Disabilities (DD) program is to incorporate family involvement into all aspects of a child'™s services, and to achieve lasting positive outcomes. To accomplish this objective, families will partner with professionals in order to design and implement interventions that will work best for them and their child. Upon a child'™s enrollment on the waiver, the Department will educate families on the array of services available to them, and will assign the family a case manager.

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 Act Early 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.

The service delivery methods are as follows: The Act Early waiver is only offered through the traditional pathway. Eligibility determinations are completed by an Independent Assessment Provider (IAP) contracted with the Department. When a child is determined eligible for waiver services they are referred to the Department or the selected contractor for case management services. The case manager completes the family-centered planning process and is responsible for coordinating services for the family. If the family chooses a non-paid plan developer the case manager will assist as needed. 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.

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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. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness 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:

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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.

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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 in-patients 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

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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:
Idaho has a well-established provider, advocate, and participant associations who provide frequent feedback to the Department regarding the programs for people with developmental disabilities (DD). The Department has a scheduled quarterly meeting with the Idaho Developmental Disabilities Agencies Association . The majority of developmental disability agencies in the state of Idaho are members of this association and have opportunities to give input on children's DD services at these meetings. The Department also has quarterly meetings with Idaho Parent's Unlimited, LLC to hear input on the children'™s DD services in the state.

Two years prior to the implementation of the waivers, the Department had meetings with a variety of stakeholder groups, to receive input on how to restructure the current children's DD program, in an effort to improve services for children with DD in Idaho. This project included families, schools, providers, advocates and other divisions within the Department to ensure all perspectives of a child's system of care were considered. Committees were created to address issues that may arise after the implementation of the program. These committees continue to meet on a quarterly basis to address any concerns with the children's DD program. In addition to these ongoing meetings, the Department has a website where updates are posted and feedback can be received on a continuous basis regarding the children's DD program. The website is available at www.childrensDDservices.dhw.idaho.gov. Each year of the waiver the Department conducts Children's Service Outcome Reviews which includes parent satisfaction on a statistically valid sample of participants. This has givens families more opportunities to give input regarding their child's DD services.

Administration and oversight of the waiver program is governed by Idaho Administrative Code. The Department typically engages in negotiated rulemaking to develop proposed changes to administrative rules. Prior to final implementation of any proposed changes to administrative rules, the proposed rules must be published in the Idaho Administrative Bulletin, the public is given an opportunity to comment on the proposed rules, and the Idaho Legislature must review and approve the proposed changes.

January 17, 2014 a Tribal solicitation letter was e-mailed and sent US mail to the federally recognized Idaho Tribes as well as the Northwest Portland Area Indian Health Board, who work closely with Idaho Tribes as a Coordinating agency. Solicitation letters are also uploaded onto a website designed specifically for communication between Idaho Medicaid and Idaho Tribes.

In addition, notice of waiver renewals were presented at the quarterly Tribal meetings on November 6, 2013 and February 5, 2014.
More recently for HCBS regulations, the following activities occurred:

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

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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 MedicAide 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.

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: Burt

First Name: Carolyn

Title: Alternative Care Coordinator

Agency: Idaho Division of Medicaid

Address: P.O. Box 83720

Address 2:

City: Boise

State: **Idaho**

Zip: 83720-0009

Phone: (208) 287-1174 **Ext:** ☐ **TTY**

Fax: (208) 332-7286

E-mail: BurtC@dhw.idaho.gov

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

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Last Name: Hettinger

First Name: Lisa

Title: Medicaid Administrator

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) 364-1831 **Ext:** ☐ **TTY**

Fax: (208) 364-1811

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:

State Medicaid Director or Designee

Submission Date:

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

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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:

NA

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

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

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

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

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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.

At the time of writing, Idaho is currently working with CMS towards approval of its Statewide Transition Plan. The Statewide Transition Plan encompasses all of Idaho's HCBS programs.

Idaho completed a preliminary gap analysis of its residential HCBS settings in late summer of 2014. 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. 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. This preliminary analysis has informed the recommendation to develop several changes to rule, operational processes, quality assurance activities, and program documentation. Please see Idaho's Statewide Transition Plan for a complete description of the analysis and findings: http://healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=Bno7zvrZytA%3d&tabid=2710&portalid=0&mid=11464

Idaho has completed its assessment of all HCBS 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. This information was obtained from a survey of Licensing and Certification staff and Quality Assurance Staff that visit these HCBS sites. Idaho will assess all settings against the third characteristic of an institution as part of its larger assessment effort in 2017.

At this time, Idaho is unable to determine how many residential and non-residential HCBS 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 will require removal from the program and/or relocation of participants. Due to the structure and oversight of Idaho Medicaid, regulatory changes are required to allow assessment of individual settings and enforcement of compliance issues. Proposed changes to the Idaho Administrative Procedures Act (IDAPA) were promulgated during 2015 with multiple opportunities for stakeholder input and feedback. These proposed rules were approved in both the Idaho House and Senate Health and Welfare Committees in February 2016, and are anticipated to become effective July 1, 2016. These rules form the foundation of Idaho's systemic remediation.

Beginning in January 2017, Idaho will begin site-specific assessments. Idaho intends to submit updated versions of the Statewide Transition Plan to CMS in July 2016 and July 2018 after public comment periods.

Idaho assures that the settings transition plan included with this amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment.

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)*:

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○ **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, 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 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 childrens developmental disabilities programs - 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
   Rules, policies, procedures and information development governing the waiver program - Division of Medicaid
   Rules, policies and procedures and information development governing the operations of the childrens developmental disability programs - Division of FACS

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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 is 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.

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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 Medicaids 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 Medicaids 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).**

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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 administer children's developmental disability case management services.

○ **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: Contract monitoring reviews the performance of the IAP on a quarterly basis.

Data collection and review: Data is collected monthly by the Departments contract monitor from the contractor that

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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 and provide information in relation to compliance, they evaluate timeframe compliance and level of care eligibility accuracy according to the Departments business model, and they also look at staff training provided during the quarter. Any complaints and resolutions that come up are tracked on an ongoing basis, and included in the 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.

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 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 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.

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.

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

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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 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.

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	☑	☑
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☐
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☐
Prior authorization of waiver services	☑	☐
Utilization management	☑	☐
Qualified provider enrollment	☑	☐
Execution of Medicaid provider agreements	☑	☐

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Function	Medicaid Agency	Contracted Entity
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☑

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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample**

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		Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Operating agency 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 Quality Management (QM) Committee meets on a quarterly basis to review 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 Medicaids 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 Medicaids 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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other**	☑ **Annually**

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Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☑ **Intellectual Disability or Developmental Disability, or Both**					
	☑	**Autism**	3	6	☐
	☑	**Developmental Disability**	3	6	☐
	☑	**Intellectual Disability**	3	6	☐
☐ **Mental Illness**					
	☐	**Mental Illness**			

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Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

A participant must have the following characteristics to qualify for Act Early waiver services:
a. An autism spectrum diagnosis: or
b. Self-injurious, aggressive, or severely maladaptive behavior as evidenced by a General Maladaptive Index score of minus twenty-two (-22) or below on the Scales of Independent Behavior - Revised (SIB-R) or other behavioral assessment indicators identified in the child's inventory of needs, and a severe deficit defined as having a composite full scale functional age equivalency is less than fifty percent (50%)of the participantâ€™s chronological age.

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:

Participants affected by the maximum age limitation may be provided the option of continued community based care through another home and community based services waiver, institutionalization, or can choose to no longer receive long term care services.

Case managers and the IAP are aware of the age limitation and will discuss the transition process during the participant's annual review, prior to the participant's seventh birthday. The latest a child may enroll in the Act Early waiver is up to 6 years 9 months. Case managers are familiar with children's waiver programs and the services offered under each waiver. A case manager may work collaboratively with service providers,the family, and the non-paid plan developers(if applicable), to ensure everyone involved in the child's system of care is informed of the transition. The case manager will explain what services are available under each waiver program and what adjustments to the child's services may be needed. The transition plan will be identified on the child's plan of service. Case managers will also discuss the option of ICF/ID or institutional placement.

To ensure a seamless transition, the child's transition plan will be included on the plan of service and will give the family sufficient notice that their child will need to transition at the end of the plan year.

Within 120 days of the expiration of the plan of service, participants electing to continue community based care through another home and community based services waiver will be notified of the steps to transition. The participant will be referred to the Independent Assessment Provider (IAP) to ensure eligibility for the particular waiver program and assign a new budget amount.

Participants who transition to another waiver program may continue to receive case management services from the same case manager. They also have the option to choose to transition to a different case manager according to their level of need and wants. The participant and family will complete the family-centered planning process to develop a new plan of service. Participants will continue to receive services during the transition process.

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.*

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○ **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:

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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	771
Year 2	926
Year 3	1111
Year 4	1332
Year 5	1599

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

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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:

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

Age 3 through 6 years old.
Must meet ICF/ID level of care.
Must have an autism spectrum diagnosis, or have self-injurious, aggressive, or severely maladaptive behavior as evidenced by a General Maladaptive Index score of minus twenty-two (-22) or below on the Scales of Independent Behavior - Revised (SIB-R) or other behavioral assessment indicators identified in the child's inventory of needs, and have a severe deficit defined as having a composite full scale functional age equivalency is less than fifty percent (50%)of the participant's chronological age.

Income at or less than 300% of SSI Federal Benefit Rate.

Families are referred to the Division of Family and Community Services when there is a potential need for developmental disabilities services for their child. At that initial point of contact they are informed of the waiver programs. Many of the families will have children enrolled in the Infant Toddler Program (ITP) prior to age three, and the ITP will inform them of the other programs and prepare them for transitioning when the child turns three.

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: [ ]

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- [ ] **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)**
- [x] **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:

- [x] **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%.**

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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. 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*):

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○ **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 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.

○ **Other**

Specify:

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

◉ **Not Applicable (see instructions)**
○ **SSI standard**

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- ○ **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

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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).

Answers provided in Appendix B-5-a 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 (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 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 (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-5-a 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

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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 that you do not need to complete this section and therefore this section is not visible.

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: 1

   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.

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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.

In addition, the participant must have:
1) An autism spectrum diagnosis and qualify based on functional assessment, maladaptive behavior, a combination of both, or a medical condition; or
2) Self-injurious, aggressive, or severely maladaptive behavior as evidenced by a General Maladaptive Index score of minus twenty-two (-22) or below on the Scales of Independent Behavior - Revised (SIB-R) or other behavioral assessment indicators identified on the inventory of needs, and a severe deficit defined as having a composite full scale functional age equivalency of less than fifty percent (50%)of the participant's chronological age.

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 participant files at the IAP offices. Participants receive written notification regarding their LOC determinations. Participants that do not meet LOC criteria are informed of their right to request an appeal.

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The annual reevaluation is the same 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 office.

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 a Level of Care assessment prior to receiving services. a. Numerator: Number of applicants for HCB services who received a Level of Care assessment prior to receiving services. 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**

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Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 Level of Care determinations made according to criteria a. Numerator: Number of Level of Care determinations made according to criteria within the representative sample b. Denominator: Number of Level of Care determinations in the representative sample

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

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collection/generation *(check each that applies):*		
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

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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 to the Department's IAP contract monitor.

The Quality Management (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, also 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*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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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 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.
The Case Manager's office.
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 "Espanol" 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)

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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**		
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.

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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**
- [x] **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

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:
Developmental Disabilities Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Developmental Disabilities Angecy (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 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

Revised for professional services:
Additional Training for Professionals. Training of all professional staff must include the following as

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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

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare
Frequency of Verification:
- At initial provider agreement approval or renewal
- At least every three 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

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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**
- [x] **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

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:
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 includes:
-Yearly Training, minimum of twelve (12) hours of formal training each calendar year that include:

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-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 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

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare
Frequency of Verification:
- At initial provider agreement approval or renewal
- At least every three 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	09011 respite, out-of-home

Category 2:	Sub-Category 2:
09 Caregiver Support	09012 respite, in-home

Category 3:	Sub-Category 3:

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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.

The cost of respite services cannot exceed 10 percent of the child's individual budget to ensure the child receives the recommended amount of intervention based on evidence-based research.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

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

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

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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", and 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
- At least every three 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:

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- At initial provider agreement approval or renewal
- At least every two 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:

Crisis Intervention

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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)*:

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- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Independent Crisis Intervention Provider
Agency	Developmental Disabilities Agency Provider

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
- At least every two 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:
Developmental Disabilities Agency Provider
Provider Qualifications
License *(specify):*

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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", and 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
- At least every three 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

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

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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 parent/legal guardian must be present and actively participate during the intervention session for at least twenty percent (20%) of the intervention time provided to the child.

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**
- [x] **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

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 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", and 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
- At least every three years, and as needed based on service monitoring concerns

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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:

Habilitative Intervention

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):*

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 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.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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

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", and 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) year's 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

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Welfare
Frequency of Verification:
- At initial provider agreement approval or renewal
- At least every three years, and as needed based on service monitoring concerns

Appendix C: Participant Services

C-1/C-3: Service Specification

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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**
- [x] **Provider managed**

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

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

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Provider Specifications:

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

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 Idaho Administrative Code.
Other Standard *(specify):*
Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide interdisciplinary training in a DDA:

- 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
- At least every three 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:
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):*

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Other Standard *(specify):*
Must meet the minimum provider qualifications under 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
- At least every two 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:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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;

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- 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**
- [x] **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	Therapeutic Consultant
Agency	Developmental Disabilities Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Consultation

Provider Category:
Individual
Provider Type:
Therapeutic Consultant
Provider Qualifications
License *(specify):*

Certificate *(specify):*

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.

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- 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
- At least every two 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 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", and 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
- At least every three 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:

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- ☐ **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.

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

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

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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 & Children's 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 completes 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*:

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○ **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, and by the Department through review and approval of Action Plans 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.

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.

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.***

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Licensing and Certification reports

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 reports

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% review of providers who are surveyed in the waiver year

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	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

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☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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):
Record reviews, off-site

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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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% Review of providers who are surveyed in the waiver year
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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 reports

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% review of training requirements for certified providers who were surveyed

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		within the waiver year
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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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*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

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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.

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 intent of the children's developmental disabilities 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 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 wide array of services and the budget levels are increased accordingly.

Evidence-based research suggests intensive intervention at an early age will result in positive outcomes for children. The Act Early waiver was created in response to this research, and gives families the opportunity to enroll in a benefit package that offers intense services early on in the child's development, in order for them to achieve the best outcomes later in life.

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 criteria for the Act Early waiver:

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- $29,300 budget

- Children meeting developmental disabilities criteria; and
- Children age three (3) through six (6) 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, and their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or

- Children age three (3) through six (6) meeting ICF/ID level of care criteria who have an autism spectrum disorder diagnosis.

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. This determination includes a functional assessment or review of the prior 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.

c) Ongoing monitoring of the budget model, complaints, appeals, and participant outcomes are conducted by the Department to ensure that assigned budgets are sufficient to assure health and safety of participants in the community. If 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. Changes to administrative code regarding the budget methodology will be subject to public feedback as part of the rulemaking process.

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 Early Periodic Screening, Diagnosis and Treatement(EPSDT)services 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 budgets 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 a written notification will be sent to the family of the decision and the right to appeal.

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, some including 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 crisis situations. Crisis intervention can be provided by a developmental disability agency and assists the family when their child's behaviors are escalating. Crisis services under the waiver provide immediate remediation and up to 24 hours of support for children in crisis, and may be provided in the child's home or in a short

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term out of home placement. The case manager is informed of the need for these services in a number of ways, some including recommendations from the family or service providers, changes in the child's condition, a critical incident, or during plan monitoring as part of progress review.

f) 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.

☐ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

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, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Idaho Medicaid presumes that HCBS furnished in a participant's own private home or exclusively in the community meet the HCBS regulations and comply with the federal HCB Settings requirements.

As described under Main, Attachment #2, Idaho has not completed its assessment of provider owned or controlled residential and non-residential settings. This assessment is planned for 2017.

Idaho Medicaid intends to implement changes to existing quality assurance processes and monitoring activities in order to ensure compliance with HCBS setting qualities for ALL settings in which HCBS are delivered in Idaho. The ongoing quality assessment process will be published in the Idaho Statewide Transition Plan and posted for public comment prior to submission to CMS. At the next waiver amendment or renewal, these details will be updated.

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 family has a choice of who will develop the plan of service for their child. 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, when the person is not a paid provider of services identified on the child's plan of service.

A case manager with the Department/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 Supervisor 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.

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 (3 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.

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.

a)Participants may choose to develop their own plan, identify a non-paid plan developer or use a case manager identified by the Department. If the participant chooses to develop their own plan or use a non-paid plan developer,

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the Department's case manager is available to assist in completing all required components. 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 (unless otherwise determined by the familycentered planning team), the parent/legal guardian and the plan developer. The plan developer is responsible for notifying the providers, who appear on the plan of service, the date of the annual family-centered planning meeting. With the parent/legal guardian's consent, the family-centered planning team may also include additional family members or individuals who are significant to the participant.

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) The plan is developed by the participant and family with their support team. The support team is typically comprised of the plan developer, the parent/legal guardian, 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 parent/legal guardian, the plan developer is the only person who is required to be a member of the support team.

The Department or its contractor, family, or non-paid plan developer develops the plan of service during the family-centered planning process. The plan developers use a standardized plan of service form to ensure consistency for families and the plan developer. If the family writes their own plan or chooses a non-paid plan developer, the Department will make the standardized plan of service form available to that family. If the plan developer is not a case manager with the Department, they must submit the plan of service to the Department for review and approval within 10 business days prior to the plan expiration date. The Departments case managers must authorize the plan of service and send it to the family/provider prior to the expiration of the previous plan of service.

(b) The IAP conducts and/or collects a variety of assessments at the time of initial application and on an annual basis.

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.

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Participants and their support team, must complete a health and well-being checklist which assess and documents health and safety issues.

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, asses 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.

(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.

(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.

(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.

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 Department's case manager will assist them with the above tasks as needed.

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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, some including 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.

(f) 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 participantÃƒÂ¢Ã‚Â€Ã‚Â™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.

(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.

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 childâ€™s developmental disability services are coordinated at the time of plan of service development. The plan of service 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.

In addition to the family-centered planning process and plan of service development, there are also services available when a child is at risk of or is experiencing a crisis situation. These services are not included in a child's budget.

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 childâ€™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) or the

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independent 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:

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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):*

- [x] **Medicaid agency**
- [ ] **Operating agency**
- [x] **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 and the 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 plan developer will assist them in exploring other provider options available to the family.
- Review of provider status reviews and complete a plan monitor summary 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.
- 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.
- 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.

c) The plan developer monitors the plan at a frequency determined by the family-centered planning team, and as authorized on the plan of service. The plan developer must make direct, in-person contact with the participant at least annually, but plan monitoring may occur more frequently as needed.

The Department also reviews and investigates critical incident reports and complaints and conducts ongoing quality assurance 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:*

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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):
Record reviews, off-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

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	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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):
Record reviews, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	

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		☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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):
Record reviews, on-site
If 'Other' is selected, specify:

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

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collection/generation *(check each that applies):*		
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

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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):
On-site observations, interviews, 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

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	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

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Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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):
Record reviews, off-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

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	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
On-site observations, interviews, 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

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Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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):
Record reviews, off-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

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	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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):
Record reviews, off-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	

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		☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:

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- 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 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 childrens 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 valid 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 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 Program Integrity 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*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

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Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Other** Specify:

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)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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

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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**

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◉ **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

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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 ÃƒÂ‚Ã‚Â– 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

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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/her self (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 damage
-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 eligiblity 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

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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 adheres 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)

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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 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 individualâ€™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.

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:
â€¢ Department plan monitoring completed at least every 6 months.
â€¢ Received complaints on an ongoing basis.
â€¢ Children Service Outcome Reviews, which are performed annually on a sample of families.
â€¢ 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.

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The Department reviews all plans of service prior to the implementation of the plan. When a provider believes the participant may require restraint 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 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

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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. When a provider 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.

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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.

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:

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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.

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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.

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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 instancesof 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☑ **Annually**	☐ **Stratified**

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Specify:		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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 waiver. a.Numerator: Number of participants or legal guardians who received information/education about how to report. b.Denominator: Number of participants receiving waiver services.

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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

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☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:

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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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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, on-site
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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

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☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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:

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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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

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Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

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 Program Integrity 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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

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Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

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;

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- 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

i. 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 FACS 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

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Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☑ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

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 Medicaids 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 Medicaids 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 MedicAide newsletter on the Department of Health and Welfares website. The MedicAide 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

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rulemaking is provided through a Legal Notice that publishes in local newspapers and the Departments 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 for Idaho Developmental Disabilities (ID. 0076), Aged and Disabled (ID. 1076), children's 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).

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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 sample claims paid according to the posted fee schedule.
a.Numerator: Number of claims paid according to the posted fee schedule.
b.Denominator: Sample of 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 claims 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

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	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

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Data Source (Select one):
Other
If 'Other' is selected, specify:
Bureau of Financial Operations financial 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 100% review of billing for a week period within the waiver year
	☐ **Other** Specify:	

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):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

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Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

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):*
☑ **State Medicaid Agency**	☑ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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**

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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

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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/staff 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

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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.

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:

Act Early waiver provider billing flows directly from the provider to the State's claim payment system, Idaho Medicaid's Management Information System (MMIS).

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 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.)*

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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, quality assurance 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.**

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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:

☐ **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.**

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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:

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:*

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

- ( ) **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

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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:

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**

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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.

○ **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:

☐ **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:

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

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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 are 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:*

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- (●) **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:

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

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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:

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	21411.44	13614.00	35025.44	91626.00	7577.00	99203.00	64177.56
2	22020.74	14295.00	36315.74	93125.00	7956.00	101081.00	64765.26
3	22718.32	15009.00	37727.32	94625.00	8354.00	102979.00	65251.68
4	23492.90	15760.00	39252.90	96124.00	8772.00	104896.00	65643.10
5	24341.87	16548.00	40889.87	97624.00	9210.00	106834.00	65944.13

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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	771		771
Year 2	926		926
Year 3	1111		1111
Year 4	1332		1332
Year 5	1599		1599

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.

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.

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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	
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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Education Total:							**810.56**
Family Education	☐	15 min.	4	17.00	11.92	**810.56**	
Habilitative Supports Total:							**2033533.04**
Habilitative Supports	☐	15 min.	322	1364.00	4.63	**2033533.04**	
Respite Total:							**136294.20**

GRAND TOTAL:	**16508217.28**
Total: Services included in capitation:	
Total: Services not included in capitation:	16508217.28
Total Estimated Unduplicated Participants:	**771**
Factor D (Divide total by number of participants):	**21411.44**
Services included in capitation:	
Services not included in capitation:	21411.44
Average Length of Stay on the Waiver:	344

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite		15 min.	126	373.00	2.90	136294.20	
Crisis Intervention Total:							12910.44
Crisis Intervention		15 min.	4	397.00	8.13	12910.44	
Family Training Total:							1773731.76
Family Training		15 min.	771	193.00	11.92	1773731.76	
Habilitative Intervention Total:							12498835.20
Habilitative Intervention		15 min.	771	1490.00	10.88	12498835.20	
Interdisciplinary Training Total:							47203.20
Interdisciplinary Training		30 min.	110	9.00	47.68	47203.20	
Therapeutic Consultation Total:							4898.88
Therapeutic Consultation		15 min.	4	72.00	17.01	4898.88	

GRAND TOTAL:	16508217.28
Total: Services included in capitation:	
Total: Services not included in capitation:	16508217.28
Total Estimated Unduplicated Participants:	771
Factor D (Divide total by number of participants):	21411.44
Services included in capitation:	
Services not included in capitation:	21411.44
Average Length of Stay on the Waiver:	344

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Education Total:							850.68
Family Education						850.68	

GRAND TOTAL:	20391207.76
Total: Services included in capitation:	
Total: Services not included in capitation:	20391207.76
Total Estimated Unduplicated Participants:	926
Factor D (Divide total by number of participants):	22020.74
Services included in capitation:	
Services not included in capitation:	22020.74
Average Length of Stay on the Waiver:	344

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 min.	4	17.00	12.51		
Habilitative Supports Total:							**2180954.16**
Habilitative Supports		15 min.	329	1364.00	4.86	**2180954.16**	
Respite Total:							**147409.60**
Respite		15 min.	130	373.00	3.04	**147409.60**	
Crisis Intervention Total:							**13545.64**
Crisis Intervention		15 min.	4	397.00	8.53	**13545.64**	
Family Training Total:							**2235762.18**
Family Training		15 min.	926	193.00	12.51	**2235762.18**	
Habilitative Intervention Total:							**15756630.80**
Habilitative Intervention		15 min.	926	1490.00	11.42	**15756630.80**	
Interdisciplinary Training Total:							**50911.02**
Interdisciplinary Training		30 min	113	9.00	50.06	**50911.02**	
Therapeutic Consultation Total:							**5143.68**
Therapeutic Consultation		15 min.	4	72.00	17.86	**5143.68**	

GRAND TOTAL:	**20391207.76**
Total: Services included in capitation:	
Total: Services not included in capitation:	20391207.76
Total Estimated Unduplicated Participants:	**926**
Factor D (Divide total by number of participants):	**22020.74**
Services included in capitation:	
Services not included in capitation:	22020.74
Average Length of Stay on the Waiver:	344

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

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Education Total:							**893.52**
Family Education	☐	15 min.	4	17.00	13.14	**893.52**	
Habilitative Supports Total:							**2341933.44**
Habilitative Supports	☐	15 min.	336	1364.00	5.11	**2341933.44**	
Respite Total:							**157555.20**
Respite	☐	15 min.	132	373.00	3.20	**157555.20**	
Crisis Intervention Total:							**14228.48**
Crisis Intervention	☐	15 min.	4	397.00	8.96	**14228.48**	
Family Training Total:							**2817518.22**
Family Training	☐	15 min.	1111	193.00	13.14	**2817518.22**	
Habilitative Intervention Total:							**19848126.10**
Habilitative Intervention	☐	15 min.	1111	1490.00	11.99	**19848126.10**	
Interdisciplinary Training Total:							**54399.60**
Interdisciplinary Training	☐	30 min.	115	9.00	52.56	**54399.60**	
Therapeutic Consultation Total:							**5400.00**
Therapeutic Consultation	☐	15 min.	4	72.00	18.75	**5400.00**	

GRAND TOTAL:	**25240054.56**
Total: Services included in capitation:	
Total: Services not included in capitation:	25240054.56
Total Estimated Unduplicated Participants:	**1111**
Factor D (Divide total by number of participants):	**22718.32**
Services included in capitation:	
Services not included in capitation:	22718.32
Average Length of Stay on the Waiver:	344

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

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Education Total:							**938.40**
Family Education	☐	15 min.	4	17.00	13.80	**938.40**	
Habilitative Supports Total:							**2507686.72**
Habilitative Supports	☐	15 min.	343	1364.00	5.36	**2507686.72**	
Respite Total:							**169938.80**
Respite	☐	15 min.	136	373.00	3.35	**169938.80**	
Crisis Intervention Total:							**14943.08**
Crisis Intervention	☐	15 min.	4	397.00	9.41	**14943.08**	
Family Training Total:							**3547648.80**
Family Training	☐	15 min.	1332	193.00	13.80	**3547648.80**	
Habilitative Intervention Total:							**24987121.20**
Habilitative Intervention	☐	15 min.	1332	1490.00	12.59	**24987121.20**	
Interdisciplinary Training Total:							**58601.16**
Interdisciplinary Training	☐	30 min.	118	9.00	55.18	**58601.16**	
Therapeutic Consultation Total:							**5670.72**
Therapeutic Consultation	☐	15 min.	4	72.00	19.69	**5670.72**	

GRAND TOTAL:	**31292548.88**
Total: Services included in capitation:	
Total: Services not included in capitation:	31292548.88
Total Estimated Unduplicated Participants:	**1332**
Factor D (Divide total by number of participants):	**23492.90**
Services included in capitation:	
Services not included in capitation:	23492.90
Average Length of Stay on the Waiver:	344

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

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Education Total:							**985.32**
Family Education	☐	15 min.	4	17.00	14.49	**985.32**	
Habilitative Supports Total:							**2687762.00**
Habilitative Supports	☐	15 min.	350	1364.00	5.63	**2687762.00**	
Respite Total:							**181188.48**
Respite	☐	15 min.	138	373.00	3.52	**181188.48**	
Crisis Intervention Total:							**15689.44**
Crisis Intervention	☐	15 min.	4	397.00	9.88	**15689.44**	
Family Training Total:							**4471715.43**
Family Training	☐	15 min.	1599	193.00	14.49	**4471715.43**	
Habilitative Intervention Total:							**31496782.20**
Habilitative Intervention	☐	15 min.	1599	1490.00	13.22	**31496782.20**	
Interdisciplinary Training Total:							**62575.20**
Interdisciplinary Training	☐	30 min.	120	9.00	57.94	**62575.20**	
Therapeutic Consultation Total:							**5955.84**
Therapeutic Consultation	☐	15 min.	4	72.00	20.68	**5955.84**	

GRAND TOTAL:	**38922653.91**
Total: Services included in capitation:	
Total: Services not included in capitation:	38922653.91
Total Estimated Unduplicated Participants:	**1599**
Factor D (Divide total by number of participants):	**24341.87**
Services included in capitation:	
Services not included in capitation:	24341.87
Average Length of Stay on the Waiver:	344

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