HCBS Waiver Amendments – Public Comments

Verbal Comments from March 4, 2016; Written Comments Submitted Post-Meeting, and Responses

Verbal and written comments were submitted by the following individuals/organizations: Mel Leviton, State Independent Living Council; Karen McKinley, Seuberts Quality Home Care; Brandi Schmidt, Living Independence Network Corp. (LINC); Bill Benkula, Idaho Association of Home Care Providers; Idaho Council on Developmental Disabilities (ICDD); American Association of Retired Persons (AARP) Idaho

W-Written V-Verbal	Comments	Responses	Waiver Amendment Language Change
W	An overall comment to improve the public's ability to provide meaningful comment to the Department would be that highlighting a section header but not the specific section that has been changed is not an effective way of communicating information for which public comment is being sought. ICDD cannot overemphasize the use of plain language in communication efforts.	Thank you for the recommendation. We agree that modifications can be made in the future to improve the public input process for waiver amendments.	No change required.
V	When looking at assurances on quality and access, the current measures are too high level to accurately identify issues. The Department should work with providers to develop improved performance measures.	Thank you for the recommendation. We plan to develop more specific indicators for quality and access issues in the future. We will solicit stakeholder input as part of this effort.	No changes to waiver amendment language at this time.

Adult DD Waiver			
W	Page 4 section I Public Input: As noted in the SPA, the Department of Health and Welfare did a good job of soliciting public comments both in person and via telephonic and webinar medias. Advocacy groups and provider associations were well represented in these hearings. While the department held a hearing on these rules 3-4 of this year, the actual state plan amendment was not available. Rather the department gave us a summary of the changes. They extended the public comment period for 30 days after the time the actual SPA would be available for review. This effort is appreciated by all stakeholders. There are opportunities for improvement in gathering public input. First public hearings are usually held in only three parts of the state. One up north, one in eastern Idaho and one in Boise. Idaho is a frontier state and many of the participants and their family members cannot drive from their homes to these three public hearings. Most Participants do not have the ability to read and write so reading the SPA online and giving written public comments may not be an option for them. State Plan Amendments (SPA) are written in a fashion that the typical layperson would have difficulty understanding the language and therefore family members are unable to assist their loved ones in understanding and commenting on changes to SPA or even changes to their services and supports. Solving this problem may well entail several changes to the current system such as extending the public comment period to allow for education at a regional level to participants and their natural supports to understand what the changes actually mean for their support and care. These trainings could be put on by regional staff after they are educated on the changes to SPA and what they mean for the participants' supports and services. Some sub assurances in the SPA rely on data systems that are not included in the SPA that if included at least as an appendix would assist participation by stakeholders and could well result in feedback that would be helpful in assisting the department in revising data collection systems such as Critical Incident Reports, Access reports and Quality Assurance sub assurances.	Thank you for your insight. We agree that modifications can be made in the future to improve the public input process for waiver amendments. The waiver application is a technical document which must provide CMS with sufficient information to ensure the waiver meets applicable statutory and regulatory requirements. We appreciate recommendations on how we might adjust our process to how we might present this technical document in a more understandable format.	No changes to waiver amendment language at this time.

	We will give feedback in detail when we reach these sections. For now it is enough to bring to the department's attention that many stakeholders would have a much better understanding of what that SPA actually means if these data collection systems were made readily available. We on got them via a request under the Freedom of Information Act as the data is currently not available just the formulas. While this would be a huge undertaking, the new federal regulations under 42 CFR 447 require increasing beneficiaries' involvement through multiple feedback mechanisms. While the department is using multiple medias currently, they are most likely not effective in getting feedback from the beneficiaries and or their families and alternatives should be considered. Federal regulations require states give the public "a minimum of 30 days to comment". In light of the complexities of these documents, the state should consider extending the comment period to allow enough time for education the participants and their families how these changes might affect their services and supports.		

W	Appendix A: Waiver Administration and Operation. 6 Assessment Methods and Frequency. Residential Habilitation Contract Monitoring. This function went from a fee for services program to a single statewide contract several years ago. We believe the contractor is performing to or above the standards set out by the department. However, requirements went from at least quarterly under the fee for service model to annually as part of the single contract. Most Certified Family Home (CFH) providers are related to at least one of the participants the support and have been required to provide more support for the same rate as hours of Developmental Disabilities Services have been reduced for our participants. In addition qualified Respite Care Providers are virtually impossible to find HCBS rules require that these Certified Family Homes run as a business and afford all the privileges, rights and opportunities that other traditional HCBS services are required to provide. Documentation is one of these requirements as a part of system. Antidotal information indicates that many of these CFH homes have converted to the Self Direct option because they felt unable to meet all of the requirements of a CFH home with such limited professional support. While this is not necessarily a bad thing, providers and advocates have been concerned that some of the participants that have moved to the self-direct waiver are not actually capable to self-direct their supports and services. Instead the move was for the convenience of the service provider. The lack of oversight could result in less choice, less community integration, increased isolation, supervision by support workers that have not been adequately trained unmet medical needs and misappropriation of personal funds. For the participants that continue to receive CFH services, their program oversight is almost entirely done via a paper process. The contractor needs to meet face to face with the participant only once per year. Any Critical Incidents that are not voluntarily reported by the CFH provider may not be identified by the contractor.	We agree that the current contractor is performing to or above the standards set by the Department. Through the Home and Community Based Services project, we are engaging in extensive outreach and providing heightened education to Certified Family Homes who furnish traditional and self-directed services. Information provided includes participant rights, future quality improvement activities and how the state will address violations of rights.	No change required.

W	Appendix C (C1/C3) Environmental Accessibility Adaptations Service Definition section b states: "Unless otherwise authorized by the department permanent environmental modification are limited to a home which is the participants' principal residence and is owned by participant or the participant's non-paid family." This policy simply does not work. Participant's that have the resources to own their own home will not qualify for Medicaid under the financial eligibility criteria. A vast majority of the individuals that access the waiver program do so in conjunction with renting housing either alone or with the assistance and resources of a housemate(s). While there is the option to purchase portable modifications, these are often inadequate and in many cases pose as much risk in their use than having nothing at all. One example would be a Hoyer lift. While these work well in houses with large bedrooms and or bathrooms, they are virtually useless in the common bathroom or bedroom settings in community based rentals. There simply is not enough room for the lift, staff and either bedroom furniture or bathroom fixtures. Trying to use one is such close quarters puts both the participant and staff at risk for injury. The same holds true with bath tub seating devices and many of the "portable modifications. Environmental accessibility Adaptations should be revised to include houses that are rented. A system like the one used by Community Action Agencies for energy saving home modifications could be developed. In the case of Community Action they have insulation and storm window installation services for people who qualify for the modifications based on income. The only caveat is the landlord has to agree not to raise the rent or sell the house for a period of five years. That type of caveat imposed by Medicaid would assure resources are used in a fashion that is efficient (used for a period of say five years) and assures participant safety that is not available to people who obtain their housing by renting.	The proposed waiver amendment did not include any changes to the waiver program's benefit package or service definitions. However, as clarification, the Department does approve permanent adaptations to a rental home with the following: • A letter from the landlord agreeing with the adaptation • The lease must include either the participant or the participant's guardian. This information is included in the document "Guidelines for Environmental Adaptations," which can be found at: http://healthandwelfare.idaho.gov/Portals/0/Medical/DevelopmentalDisabilities/EnvAccModGuidelines.pdf?ver=2015-04-23-101500-293	No change required.

W	Appendix C C1 Delivery of Case Management Services This section of the SPA has been revised to reflect the new requirements imposed on states by CMS. These new requirements have an emphasis on the person center planning process. In our discussion within the Community Work Group most agree that these new requirements will most likely result in an need for increased hours for case manager/support brokers to teach and prepare the participant to self-direct his/her person centered plan to the greatest extent possible.	Thank you for your feedback. The Bureau of Developmental Disability Services (BDDS) is currently meeting with plan developers and other stakeholders to discuss possible modifications to the Adult DD person centered planning process. If process changes occur, the State will submit the necessary waiver amendment to address new requirements and possible adjustments to service limitations.	No changes to waiver amendment language at this time.
W	Appendix C Participant Services. C-4 Additional Limits on Amount of Waiver Services In this section the state discuss the prospective budgeting process, and the safeguards to assure that if a budget does not meet the individual's need how to request exception reviews appeals and hearings. I March of this year the 9th circuit Supreme Court ruled that these processes are too cumbersome to allow a lay person to be able to understand how their budget was derived and make an adequate appeal. The court also ruled that there is no definition of health and safety and finally that participants should be afforded someone competent to represent them in hearing and appeals. It would seem based on this ruling that there is a lot of work to do in this area to meet not only CMS requirements but also to assure that the participant's constitutional rights are protected. The current system of doing appeals seldom is done in person. People appealing their budget should be allowed to participate in person if they wish.	The Department is currently conducting a legal review and analysis to determine impacts on the developmental disability program as a result of the recent court ruling.	No changes to waiver amendment language at this time.

W	Appendix D Participant-centered Planning and Service Delivery D-1 Service Plan Development The SPA in this section identifies that at annual re-determination that in addition to the medical social and developmental assessment, the SIB-R and a health and physical that other evaluations can be requested to assure that the budget meets the actual needs of the participant. One of the additional assessments listed is a risk assessment. Risk assessments can take many forms depending on the risk we are assessing. One would assume that these additional assessments would be considered medically necessary and paid for via Medicaid. This is not the case with regards to inappropriate sexual behavior risk assessments. Medicaid has not sexual risk assessors signed up to accept Medicaid. In the recent past the department has required these assessments and insisted that they be paid for by the participant. We see this as being an undue burden on the participant and we encourage the department to solicit sexual risk assessors and get them signed up is Medicaid providers. The department is aware of this issue but has not made efforts to ameliorate the situation.	The proposed waiver amendment did not include any changes to required assessments. However, as clarification, the Department addressed this concern as part of the new Independent Assessment Provider (IAP) contract. Beginning in September 2016, the IAP contractor is required to complete a sexual offender risk assessments if a participant has a need in that area.	No change required.
W	Appendix D Participant-centered Planning and service Delivery. D-1 Service Plan Development. f. Informed Choice of Providers The SPA states that at the assessment process the participants are provided with a list of service coordinators and information regarding the MMCP. While this seems like a helpful thing to do, it is important to note that a majority of the individuals we support do not have the capability to read, or comprehend this written information. We would suggest that other Medias be explored to truly assist participants to self-direct their decisions about who to choose as a services coordinator and to decide if they wish to enroll in the MMCP.	Thank you for your feedback. We appreciate recommendations on how we might adjust our process to how we might present information in a more user-friendly, understandable format.	No change required.

W	<u>Appendix D Participant-centered Planning and service Delivery. Quality Improvement: Service Plan</u> In this section CMS wants states to (sub-assurance) "Service plans address all participant' assessed needs (including health and safety risk factors) and personal goals either by the provision of waiver services or through other means" Idaho is submitting a performance measure of a numerator of the number of service plans reviewed that document participants' needs and health and safety risk factors identified in the individuals' assessment and a denominator of the number of service plans reviewed in the representative sample. When you actually look at the data derived the definition changes from what is described in the SPA. The actual data sheet shows a numerator of "number of plans reviewed that indicates services were delivered consistent with the approved plans" and a denominator of" the number of plans reviewed". There seems no connection with assuring health and safety or personal goal. Rather the measure seems to be one of the approved plan divided by implementation of that plan without any identification of gaps unmet needs etc.	Medicaid agrees that the Performance Measures required modifications. We updated the Quality Improvement Performance Measure to address understandability. Sub-assurance (a) requires that 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 to demonstrate compliance with this requirement include: Number and percent of service plans reviewed that address participants' needs and health and safety risks as 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. 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. 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. b. Denominator: Number of service plans reviewed in the representative sample	Waiver amendment language was modified.

W	Appendix D Participant-centered Planning and service Delivery. b. Methods for Remediation/fixing Individual Problems In this section there is a significant amount of information about the internal processes by the division of Medicaid and family and Children Services What is missing is the necessary interaction with the participants and services providers to accurately identify what is going on in the field... Care Manager and bureau chiefs are far removed from direct service delivery. Often the issue can be easily resolved once the problem is accurately identified. We would suggest that the department reach out to the industry and participants as well as advocacy groups before implementing system wide changes. This suggestion aligns with the new requirements in 42 CFR 447.	Thank you for the recommendation.	No changes to waiver amendment language at this time.
W	Appendix G- Participant Safeguards. i sub-assurances: Here the department describes the process of identifying abuse neglect and exploitation. While the system identifies and does its best resolve individual instances, there is no measure for systemic issues to meet this assurance. To identify these issues on a systemic level, criteria of how many instances are acceptable from base line. Review of the actual spread sheets show a summary of critical incidents reported by year and quarter. There is no criterion that the state has identified that would help identify a systemic issue.	Thank you for your feedback. We agree and plan to develop more specific indicators and baseline for complaints/critical incidents in the future.	No changes to waiver amendment language at this time.
W	Appendix I: Financial Accountability. b. Sub-assurance The department uses the performance measure of the number and percent of posted rates that are consistent with the approved waiver rate methodology. In 2006 Idaho embarked on a rate study using the methodology currently approved by CMS for services under the HCBS Waiver umbrella. However, DDA agencies and Certified Family Home rates have not been adjusted to reflect this new rate methodology. The department states that these rates will not change unless there is an access problem within the system. That is not consistent with the assurances in this SPA.	The proposed performance measure is a mechanism to quantify and assist Idaho Medicaid in assuring compliance with financial accountability requirements. The Division of Medicaid's Bureau of Developmental Disability Services Quality Assurance Team is responsible for identifying and addressing any statewide resource or program issues identified through the monitoring of performance measures.	No change required.

W	Appendix I: Financial Accountability.I-2: Rates, Billing and Claims.d. In this section the department discusses the department's program integrity unit uses a utilization review system that categorizes providers by type and does a peer group analysis and ranks probable abusive patterns. This system does not take into account DD provider types that may be willing to support the most complicated and staff intensive participants. Being willing to offer such services will most likely result in a visit from MPIU if only a program designed to identify outliers is utilized to make decisions about who get integrity unit reviews. Asking program people about specialty (e.g. extreme behavioral issues or medical needs) service providers to assure that these are identified before assuming a pattern of abuse.	The proposed waiver amendment did not include any changes to the billing validation process. However, as clarification, when reviewing for fraudulent billing patterns, the Medicaid Program Integrity Unit (MPIU) does not identify an agency as an outlier if they are following an approved plan. The Department does not assume a pattern of abuse based on the amount of approved services a participant accesses.	No change required.

W	Page 16: Health and Safety Reporting Adults and children with disabilities are abused and neglected at higher rates than individuals without disabilities. People with developmental disabilities often don't know they are being abused, neglected, or exploited. Abuse most often happens at the hand of those closest to the individual. Disability Rights Idaho has seen an increase in abuse/neglect in the past several years, recent data: ➢ Neglect in facilities – 36 ➢ Abuse in facilities – 28 ➢ Death in facilities – 18 (a significant increase) • In 2014, 1,944 investigations were conducted by Adult Protective Services (APS) • In 2015 there were over 2500 report to APS units with a total of 656 alleged cases of self-neglect investigated • In 22% of those cases the individual likely had developmental or physical disability Given this information, it is imperative that work be done to improve the overall quality assurance for participants as it relates to health and safety and achieving individual outcomes. ICDD strongly recommends that Idaho participate in the National Core Indicators (NCI) project for the adult developmental disability population. Participating in NCI will allow Idaho to track our performance over time, compare results with the other states currently enrolled, and support data driven decision making. The benefits to Idaho of enrolling as an NCI state include: • Outcome measures creating performance benchmarks • Provider cost information gathered by an independent party • Creates a collaborative focus of effort with service providers and • Assists with some CMS waiver reporting	Thank you for your feedback. We share your concerns about abuse and neglect of these vulnerable individuals. We are currently exploring the use of National Core Indicators (NCI) for waiver monitoring.	No change required.

W	*Page 80: Methods for Discovery: Qualified Providers* ICDD strongly recommends training to support staff to facilitate the understanding of supporting individuals to experience learned consequences by having personal control over their resources. The current culture may need assistance in understanding how to implement strategies to transition from controlling resources of individuals in order to protect people from potential mistakes to a planned approach for learning how to responsibly spend money. Improved provider qualifications with demonstrated competencies should be tied directly to a higher reimbursement rate.	Thank you for your feedback. The proposed waiver amendment did not include any changes to the qualifications of providers. Through the Home and Community Based Services project, we are engaging in extensive outreach and providing heightened education to providers of traditional and self-directed services. Information provided includes participant rights, future quality improvement activities and how the state will address violations of rights.	

W	*Page 92: Supporting the Participant in Service Plan Development.* People other than the individual receiving services often decide what will be on their service plan and are often the ones who provide response/feedback on the quality of services. Completing checklists, monitoring paperwork/plans does not adequately ensure quality of, and best practice in, direct services provided to individuals. Assuring participant leadership in directing their service plans, choice, community access, and integration involves more in-depth person-centered planning and quality assurance monitoring. There is no evidence from the assessment activities that any documentation will be required of the service coordinator or support broker for a pre-planning meeting to assist participants with the preparation necessary to lead their person centered planning meetings. ICDD recommends some demonstration of a pre-planning be provided to indicate the support required in order to assist individuals to be in a position to lead their meetings. This area of person centered planning likely would benefit from quality training with a focus on leadership by the participant. ICDD has a depth of knowledge with best practice approaches to person centered planning due to a Person-Centered Planning Implementation Federal Grant awarded to ICDD in 2007. The grant allowed Idaho to develop intensive training for professionals and demonstrate a model of quality individualized planning that maximizes the flexibility and control of the individual while encouraging participation of the community in meeting the person's needs. Instead of focusing primarily on the paid service providers in the person's life, Planning Specialists assessed, intervened and supported those individuals who are often overlooked – extended family, friends, neighbors, and others – whose involvement with the person with a disability often makes the difference between living an isolated existence and enjoying a rich and rewarding life. The PCP model provided in-depth training on person-centered planning that had not previously existed. The funding allowed for best practice training for 14 Person-Centered Planning Specialists. ICDD recommends the Department consider "Person Centered Planning Specialist" as a new service provider within the system. This specific service provision allows for highly trained and skilled PCP facilitators whose sole responsibility would be the facilitation of a quality participant directed person centered planning. The role of the service coordinator	Thank you for your feedback. The Bureau of Developmental Disability Services (BDDS) is currently meeting with plan developers and other stakeholders to discuss possible modifications to the Adult DD person centered planning process. If process changes occur, the State will submit the necessary waiver amendment to address new requirements.	No changes to waiver amendment language at this time.

	would be to champion the plan and work to develop natural community supports. Individuals report not having a choice of roommates within certified family homes and supported living. Individuals also report meeting the provider and roommates of the certified family home or supported living residence on the day of their move. ICDD recommends supporting the practice of individuals having the ability and support to interview potential service providers and potential roommates before selecting their new place of residence. It appears that most participants have little to no control over their place of residence and choice of roommates. Individuals do not appear to know their rights, know they have the ability to say no to an option presented, or additional options available to them.		

A&D Waiver			
W	In reviewing the Idaho Transition Plan – Version 3 Updated, CMS Feedback on Transition Plan - Response to Questions – Sept. 2015, the A&D Waiver Draft and Idaho's Compliance Timeline, I have the following concerns/questions: • The way I read it, the RALFs and CFH are completing a self-assessment as the first assessment phase. This seems tantamount to "the fox guarding the henhouse." It appears that the state will not conduct on site reviews of more than a "representative sample" group, beyond the required licensing and certification reviews, which for RALFs is five years, new licenses and complaints. Please address. • Is the self-assessment available for public review? • "Idaho's Compliance Timeline" states that, "Corrective action plans will be issued as needed during the assessment process." The Timeline continues, "Participants will be notified of any setting that is not or will not be HCBS compliant and they will be provided assistance in finding an alternate HCBS compliant setting." o Who will be providing said assistance? o Will financial resources be available to help with an unanticipated move? o Will participants and/or families/grdns be notified when corrective action plans are issued during the assessment process? This would allow time for the individual and/or family/grdn and PCP team to evaluate the situation and potentially locate another living arrangement if needed. o What is the Department's plan to ensure individuals have the resources, to maintain placement in their community of choice, should relocation be necessary due to noncompliance, especially in rural areas with limited options? Additionally, the Department indicates that the current Idaho HCBS settings do not require additional scrutiny regarding a possible similarity to a facility. How was that determined given that there are 287 RALFs in 360 buildings with 9743 beds among them, not to mention 2200 CFH, a significant number of which are not operated by participants' families? (* figures: IDHW website)	The self-assessment is a tool intended to assist providers in gauging their current level of compliance and in identifying changes needed to become compliant. Idaho's determination of provider compliance with the HCBS regulations will be based on on-site reviews and existing monitoring mechanisms, not on providers' assessment of their own level of compliance. The processes that are currently in place to facilitate provider changes will be used in the event that noncompliant HCBS settings are identified. An updated version of the Statewide Transition Plan will be available again for public comment in July 2016. In that plan, Idaho indicates that a number of RALFs and CFHs will in fact undergo the heightened scrutiny process.	No change required.

W	Appendix D: Participant-Centered Planning and Service Delivery D-1: Service Plan Development (2 of 8) Note the following ongoing concerns related to Nurse Reviewers providing information about "Choice." As expressed by meeting participants and confirmed by Medicaid staff during the March 4, 2016 public meeting – true Person Centered Planning (as defined by CMS) – is most generally not currently happening during the LOC/UAI assessment. Most often, the individual and the family do not understand that the assessment as part of their "freedom of choice." They don't understand that this is the beginning of a "person centered plan." The participant and/or family/grdn view the nurse reviewer as a qualified medical professional who is telling them what they need and may offer a few suggestions about where they can get it. • In the "discussion with the participant (family or legal representative, as appropriate)" what is discussed and for how long? How will the Department ensure that the Nurse Reviewer knows of available services in the area served; and has time (due to staffing shortages and Medicaid billing) to discuss the options with the participant and parties involved in a manner that is understandable to the participant/family/grdn?	Thank you for your feedback. There are currently no parameters around the length of discussion/conversation with a participant during the UAI/LOC assessment process. If an individual has needs that cannot be addressed by the waiver program, the Nurse Reviewer refers that person to appropriate resources. If the Nurse Reviewer does not know of a resource, the individual is referred to the 2-1-1 Idaho CareLine. It is a statewide community information and referral service that has a comprehensive database of Idaho's programs and services. Based on the current workload, Nurse Reviewers do not function as service coordinators/case managers.	No changes to waiver amendment language at this time.

W	Related to the individual's Person Centered Planning (PCP) meeting: Based on the issues above and statements made by Department staff during public meetings, I have further concerns related to Appendix D 1. Service plan development: b., c., d., e., g.; and 2. Service plan implementation. Under the A&D waiver, individuals and their families currently are at the mercy of the time and competency level of the agency that provides their services for Person Centered Planning. There is no care coordinator unless they have TruBlue. Again, how does the Department plan to ensure individuals have PCP as defined by the HCBS rules? By the time an individual applies for Medicaid, gets Medicaid, and has been evaluated by doctors, nurse reviewers, etc., they willingly sign anything put in front of them by a person they see as having power or greater knowledge than they. Often times, they aren't even aware there is a plan into which they actually have a say. To be clear, I'm not saying anyone is doing anything wrong. However, the above is often the reality of an over stretched, undercompensated system. To suggest that the current system can be expanded, actually implementing and following the HCBS rules within cost neutrality appears unrealistic and disingenuous.	Plan development for A&D waiver participants currently occurs in two steps. The Department will be exploring ways to enhance our model of plan development in the future with regards to both the Nurse Reviewer and the provider agency functions.	No changes to waiver amendment language at this time.

W	What is the process that will actually follow through when a complaint is made? How will individuals know they can even make a complaint about their rights and have anyone take them any more serious than they do now? Many individuals are afraid to complain about anything because they fear losing what little independence they have. I have seen the trainings and information on the website and during public meetings. Many, many individuals who live in their own homes, in CFHs and RALFs don't have access to or understanding of the information provided about their rights. "Person Centered Planning" is not terminology used by anyone who is not of the disability/public health world. PCP development, implementation and monitoring, particularly within CFHs and RALFs will require additional scrutiny to ensure that individuals have the same access to keys, food, visitors, choice of roommates, community activities and events, etc. as they would in their own home. If they don't have such, then it must be fully documented in their plan according to the HCBS rules – for how many of the 9743 people just residing in RALFs? How will this be effectively and fairly monitored within cost neutrality?	The Bureau of Long Term Care (BLTC) has a complaint logging/investigation process that is described in Appendices F and G of the waiver application. All complaints received are documented and examined for substantiation. The BLTC will be examining and collecting data on service plans in RALFs/CFHs, including documentation of instances where exceptions to the HCBS rights (such as access to food, visitors, choice of roommates) have been implemented inappropriately or without approval from the Department. Providers will be educated on the process for documenting and submitting requests for exception to the Department for review. Participants will be provided with additional information about their rights, including the rights under the new HCBS IDAPA rules, during the redetermination process with the Nurse Reviewer. The HCBS project as a whole is engaging in heightened education on participant rights and how to address violations of rights.	No changes to waiver amendment language at this time.

W	While I understand that it is not the purpose of this comment to deal with rate issues, I'm asking that it be addressed sooner rather than later. Department personnel have stated in public meetings that rates for personal assistant services/care attendants will not increase unless quality and access needs arise and the provider survey issue is resolved. Given the current A&D rate structure individuals cannot access the enough PAS hours to remain in their homes. Department personnel have stated that there is not evidence of an access issue since participants haven't brought it to their attention. There appears to be a disparate impact tied to the daily living rates for those on the A&D waiver versus those on the DD waiver. Common sense indicates such when you look at Medicaid codes for H2015, H2016 and H2022 under both the A&D and the DD. Same code, different rate. The reasoning given is that some providers would not complete the required survey. While 100% survey completion is of course to be done, it is unreasonable to compare the cost of a quasi-community placement (RALFs & CFHs) to daily supports provided by an agency in an individual's home. Given the HCBS requirements for authentic person centered plans and true community placement, it appears that quality and access issues are likely to arise sooner rather than later.	Thank you for your feedback. We plan to develop more specific indicators for quality and access issues in the future. We will solicit stakeholder input as part of this effort. The court ruling regarding residential habilitation – supported living services (H2015, H2016, and H2022) was specific to providers and participants with developmental disabilities.	No changes to waiver amendment language at this time.
W	Consumers, to the extent that they are capable, or their caregivers or legal representatives, should be provided with viable options in order for them to make decisions about the LTSS they receive. Benefits should be designed to enable consumers to choose services they deem most appropriate for their needs. Idaho should identify barriers that unintentionally curtail consumers' ability to self-direct their care.	Thank you for your feedback. The proposed waiver amendments do not include any changes to the waiver program's benefit package. Currently, program participants have the ability to choose from among the services for which they are eligible. They also have the option to use a fiscal intermediary to self-direct some of the services that are available.	No changes to waiver amendment language at this time.
W	All Medicaid managed care LTSS plans should offer, promote, and support consumer-directed care with timely access to services. A person-and family-centered planning process should reflect people's preferences and goals. This planning should empower older adults and people with disabilities by recognizing that the person receiving services is the expert in his or her own care. Individuals should be active in their own planning and may include other people of their choosing, such as family caregivers.	We concur with these comments.	No change required.

W	Conflict-free care management should be an essential part of any LTSS system, ensuring effective and efficient coordination of high-quality client services. Individuals and families should be afforded conflict-free assessment, counseling, and assistance prior to entering any type of LTSS system or any time at the request of the individual or family.	The A&D waiver program does not include case management. Conflict-of-interest issues are minimized in the A&D waiver program because the Department conducts the UAI/LOC assessment that determines units/authorized services. Options counseling would ideally occur prior to entry into the A&D Waiver program.	No change required.
W	Idaho should encourage LTSS providers to establish ongoing quality improvement programs. These programs should objectively and systematically monitor and evaluate the quality and appropriateness of care, determine ways to improve care, resolve identified problems and base staffing on residents' and clients' care needs.	Idaho requires our providers to have quality improvement programs in place.	No change required.
W	Managed care LTSS programs should support – not necessarily replace – the care received from families and friends. Idaho should recognize and assess family caregivers' own needs as part of a person- and family-centered care plan.	The existing assessment process identifies natural supports that are available (or, conversely, not available) to an individual in meeting their needs. All services currently available on the A&D waiver are furnished to the participant, not unpaid caregivers.	No changes to waiver amendment language at this time.
W	Assistance for family caregivers should include education and training, counseling, legal consultations, hospice and respite care, adult day services, support groups, mental health counseling and programs that help individuals pay relatives who provide care and supports. In a person- and family-centered approach, family caregivers are also viewed by health and LTSS professionals as part of the care team.	While we recognize the importance of family caregivers as part of the care team, all services currently available on the A&D waiver must be furnished to the participant.	No changes to waiver amendment language at this time.
W	Education and training programs for family caregivers should ensure that they are well trained and prepared to perform LTSS tasks such as bathing, but also more complex medical and nursing tasks such as medication management and wound care.	Paid caregivers are required to undergo training in tasks that support participants. The A&D waiver does not include services furnished to unpaid caregivers, such as training.	No changes to waiver amendment language at this time.

V	The Department should conduct a cost survey for A&D waiver services. There is a quality and access issue when only 21 people are accessing Residential Habilitation under the A&D waiver.	Thank you for your feedback. We plan to develop more specific indicators for quality and access issues in the future. We will solicit stakeholder input as part of this effort. The waiver application does not house the Department's process and requirements for cost surveys.	No change required.
V	There is a quality and access issue in Region 2 for A&D waiver services. The Department should conduct a cost survey.	Thank you for your feedback. We plan to develop more specific indicators for quality and access issues in the future. We will solicit stakeholder input as part of this effort. The waiver application does not house the Department's process and requirements for cost surveys.	No change required.
V	There is a quality and access issue in Regions 3, 4, and 5. A&D waiver providers pulled out of a cost survey because the rate was bundled with Certified Family Home and Residential Assisted Living Facility rates. They need to be surveyed separately.	Thank you for your feedback. We plan to develop more specific indicators for quality and access issues in the future. We will solicit stakeholder input as part of this effort. The waiver application does not house the Department's process and requirements for cost surveys.	No change required.

Act Early 1915(c)			
W	**Recommendation #1:** Page 17-18: *"If items are identified as deficient during the reviews, an Enhanced review will be conducted."* Although the process of CSOR is described above this statement, there is no explanation about what an "Enhanced review" involves. ICDD recommends providing detailed information about what this will include. Additionally, it is unclear why there is redundant information about both of these quality assurance measures on page 17 and 18.	"Enhanced review" is defined on page 90. The format of the waiver application dictates some degree of redundancy, particularly with the quality assurances.	No change required.
W	**Recommendation #2:** Page 35: *Evaluation/Re-evaluation of Level of Care* There are highlights on this page that indicate a change in the Amendment from the approved Waiver, however, the only change noted is that on (b) there was no table. Throughout the section there is no significant change between the two documents.	CMS no longer requires a performance measure for this subassurance, so the table was in fact removed. The waiver application does not permit the state to remove the subassurance and its instructions from the document.	No change required.
W	**Recommendation #3:** Page 45: *Other Standard* "Optimal independence" is noted as a quality that a HS provider should have. ICDD recommends providing detail around this quality, exactly what it is, how it is measured, and demonstrated competencies for the Department to insure that provider has the quality. ICDD also recommends a need for clarification that direct care staff should be instructed by a knowledgeable individual about the needs of the person to whom they are providing the service. This would ensure that the child will receive the optimal service.	Thank you for your feedback. The proposed waiver amendment did not include any changes to the qualifications of providers. Through the Home and Community Based Services project, we are engaging in extensive outreach and providing heightened education to providers of traditional and self-directed services regarding service delivery expectations. This information includes participant rights, future quality improvement activities and how the state will address violations of rights. .	No change required.

W	**Recommendation #4:** Page 47: *Respite* ICDD recommends adding "knowledgeable individual" as a requirement for the person providing training to the respite provider.	Thank you for your feedback. The proposed waiver amendment did not include any changes to the qualifications of providers. Through the Home and Community Based Services project, we are engaging in extensive outreach and providing heightened education to providers of traditional and self-directed services regarding service delivery expectations. This information includes participant rights, future quality improvement activities and how the state will address violations of rights.	No change required.

Children's DD 1915(c) Waiver			
W	**Recommendation #1:** *Page 23: Qualifications* There is no mention of children who are accessing Katie Beckett services (Home Care for Certain Disabled Children) participating in the Children's Waiver provided they meet ICF/ID level of care. ICDD recommends including this as an option for those families who live outside of 300% FPL.	The Medicaid income guidelines are applied only to the child, rather than the entire family, in cases of children that are eligible under Katie Beckett Medicaid. Therefore, the 300% of FPL does also apply to that group of children.	No change required.
W	**Recommendation #2:** *Page 41 and 44: HS & Respite provider qualifications* *For Habilitative Support and Respite providers, the qualifications state the person providing the service has "received instructions in the needs of the participant who will be provided the service."* ICDD recommends providing a clarifying statement that the individual providing the training has some knowledge about the child. Suggested revision would be "*…have received instruction by a knowledgeable or informed trainer in the needs of the participant who will be provided the service.*"	Thank you for your feedback. The proposed waiver amendment did not include any changes to the qualifications of providers. Through the Home and Community Based Services project, we are engaging in extensive outreach and providing heightened education to providers of traditional and self-directed services regarding service delivery expectations. This information includes participant rights, future quality improvement activities and how the state will address violations of rights.	No change required.
W	**Recommendation #3:** *Page 81: Case Manager Training & Qualifications* A statement reads: *"case managers are trained in family-centered planning."* ICDD suggests providing detail regarding who provides the family-centered training, the duration of the training, and if the training is based on best practice for family /person centered planning.	The addition of HCBS regulation requirements to the waiver template has enhanced the description of the person-centered planning work. The Division of Family and Community Services (FACS) continues to train their regional case managers on a quarterly basis.	No change required.

W	**Recommendation #4:** *Page 84: Plan Monitoring* *"Plan monitoring needs to occur at least annually or as determined by the family."* There is a quality assurance issue within both FDS (especially in FDS) in that there may be no other unbiased individual who has seen the child for 12 months. Because of the trend towards home-schooling in Idaho, ICDD recommends that the Department consider monitoring take place with quarterly face-to-face visits by the Plan Monitor to assure that services are being delivered according to the plan and also to assess the well-being of the individual receiving the services.	We appreciate your recommendations. Data gathered for plan monitoring is from the CSOR which does a face to face visit with the representative sample.	No changes to waiver amendment language at this time.
W	**Recommendation #5:** *Page 97: Family Directed Services: Information to families* *"The Department holds regular information meetings where families can learn about Family Directed Services."* ICDD recommends improved advertising of these trainings with training provided in rural areas. There is also a need for trainings provided in languages other than English.	Thank you for the recommendation. Translation services are available for persons with limited English proficiency. We will share your recommendation regarding increased advertising of trainings in rural areas.	No change needed.
W	**Recommendation #6:** *Page 101 Budget* ICDD recommends clarifying language that when a child transitions from FDS to Traditional services (or vice-versa) mid-plan year, that their remaining budget follows them—no new money is assigned until the child's redetermination date.	Thank you for your recommendation. Transitioning from one waiver program to another mid-year is currently being reviewed on an individual basis to account for budget dollars that have already been spent for the year.	No changes to waiver amendment language at this time.