

EXECUTIVE SUMMARY

In 2012, the Bureau of Developmental Disability Services, Idaho Division of Medicaid was approved for the Developmental Disability Waiver. This document reflects the evidence that supports the Quality Improvement Strategy (QIS) submitted as part of that DD Waiver application. It includes the measures, processes and data Idaho used to determine that each waiver assurance has been and continues to be met during the period that the waiver is in effect (discovery); the measures and processes employed to correct identified problems (remediation); the roles and responsibilities of the parties involved in measuring performance and making improvements; the processes employed to aggregate and analyze trends in the identification and remediation of problems; the processes employed to establish priorities, develop strategies for, and assess implementation of system improvements, October, 2012 through September 30, 2015

ROLES & RESPONSIBILITIES

The Division of Medicaid, Bureau of Developmental Disability Services has a Quality Oversight Committee, whose function is to review quality improvement strategy findings and analysis (including trending), formulate remediation recommendations, identifying and addressing any statewide resource or program issues identified in the QA/QI business processes. The Quality Oversight Committee is a team that includes the Bureau Chief, Program Managers, Policy Staff and Contract Monitors.

The results of the BDDS findings and recommendations are presented to the Bureau Leadership Team (BLT).

The BLT is responsible for reviewing BDDS and other Medicaid program reports, analyses and recommendations, considering Division-wide resources, coordination issues and strategies. The Central Office Management Team (COMT) then makes final system-wide change decisions.

Quality Assurance Staff, Care Managers and Program Managers are responsible for remediating any specific caseload performance issues and/or training and educating staff on any adopted statewide design changes.

The Quality Manager is responsible for training and educating the Quality Assurance Staff on any adopted statewide design changes.

TOOLS & PROCESSES

The following processes (Quality Improvement Strategies) are used to monitor, remediate and make system improvements in the DD waiver. Each process results in the reports that are included in the HCBS Quality Review.

- **Complaint and Critical Incident Report** - All complaints and critical incidents received are recorded in the SharePoint data system and require specific dates, nature of complaint/critical incident, narrative, referrals or plans of correction when necessary, a classification of substantiated or unsubstantiated and a closure date. Of the 30 performance indicators defined in the BDDS Quality Improvement Strategy to measure Waiver Quality Assurances, the Complaint and Critical Incident Report collects information on 4 of those indicators. The BDDS goal is to meet 100% in each performance indicator. Findings below 100% required remediation and further analysis for quality improvement measures
- **Participant Experience Survey** - The Participant Experience Survey (PES) is administered to all participants receiving 1915(i) and/or 1915(c) DD Waiver Traditional or Consumer Directed services. The survey is administered to Participants completing their annual eligibility assessment. Participants are highly encouraged, but not required, to participate in the PES process. Participants completing their initial eligibility assessment will not be offered the opportunity to complete a PES. The PES is used to provide feedback about participants' experience with the services and supports they receive. Of the 30 performance indicators defined in the BDDS Quality Improvement Strategy to measure Waiver Quality Assurances, the PES collects information on 3 of those indicators. The BDDS goal is to meet 100% in each performance indicator. Findings below 100% required remediation and further analysis for quality improvement measures.
- **Care Manager Reports** - Care Manager Reports are used to track the number of plans that were processed prior to the expiration date. Of the 30 performance indicators defined in the BDDS Quality Improvement Strategy to measure Waiver Quality Assurances, the Care Manager Reports collects information on 1 of those indicators. The BDDS goal is to meet 100% in each performance indicator. Findings below 100% required remediation and further analysis for quality improvement measures.

- **Adult Services Outcome Review** - The Adult Services Outcome Review (ASOR) process for traditional DD services and the Consumer-Directed Community Supports (CDCS) option involves the utilization of file reviews, interviews, reviews of Developmental Disability (DDA)/ Residential Habilitation (RH) agencies in coordination with Licensing and Certification (L&C), initiation of any follow-up (as needed), and program improvement, involving remediation and Plans of Correction (as needed). The review is conducted annually and selects a statistically valid random sample of DD Waiver participants for review. Of the 30 performance indicators defined in the BDDS Quality Improvement Strategy to measure Waiver Quality Assurances, the ASOR collects information on 6 of those indicators. The BDDS goal is to meet 100% in each performance indicator. Findings below 100% required remediation and further analysis for quality improvement measures.
- **Provider Quality Assurance Reviews** - Bureau of Developmental Disability Services Provider Agencies who have any active billing of selected waiver services in the last two (2) years will be reviewed on a two (2) year cycle. BDDS Agency Administrative Quality Assurance reviews may need to be conducted more often in some circumstances due to the type and amount of corrective action plans the agency has on the final report of each review. Of the 30 performance indicators defined in the BDDS Quality Improvement Strategy to measure Waiver Quality Assurances, the Provider Quality Assurance Reviews collects information on 3 of those indicators. The BDDS goal is to meet 100% in each performance indicator. Findings below 100% required remediation and further analysis for quality improvement measures.
- **Licensing and Certification Reports** - The Licensing and Certification Reports track the number and type of surveys conducted, including information on compliance and corrective action plans. Of the 30 performance indicators defined in the BDDS Quality Improvement Strategy to measure Waiver Quality Assurances, the Licensing and Certification Reports collects information on 2 of those indicators. The BDDS goal is to meet 100% in each performance indicator. Findings below 100% required remediation and further analysis for quality improvement measures.

- **Contractor Reports** - Independent Assessment Provider (IAP) Contract Monitoring Reports: Quality Assurance Reports are submitted by the IAP directly to the Department Contract Monitor on a quarterly basis in order to document that contract compliance standards are met. If deficiencies are identified, the Department implements and documents contract corrective action. Residential Habilitation Program Coordination (RHPC) Contract Monitoring Reports: Quality assurance reports are submitted by the RHPC directly to the Department contract monitor on a monthly and annual basis in order to document that contract compliance standards are met. If deficiencies are identified, the Department implements and documents contract corrective action. Of the 30 performance indicators defined in the BDDS Quality Improvement Strategy to measure Waiver Quality Assurances, the Provider Quality Assurance Reviews collects information on 9 of those indicators. The BDDS goal is to meet 100% in each performance indicator. Findings below 100% required remediation and further analysis for quality improvement measures.
- **CMS-372 Report** - The CMS-372 is a waiver report which is completed annually to provide information on the quality of waiver services and to demonstrate that the waiver has been cost-neutral. This report demonstrates the actual performance of the waiver against the state's cost-neutrality projections. Information required in the report includes the unduplicated number of persons who participated in the waiver during the waiver year, the number of participants who utilized each waiver service, the amount expended for each waiver service and for all waiver services in total, the average annual per participant expenditures for waiver service, the total number of days of waiver coverage for all waiver participants and the average length of stay, expenditures under the state plan for non-waiver services that were made on behalf of waiver participants and average per participant expenditures for such services and information about the impact of the waiver on the health and welfare of waiver participants.

SYSTEM IMPROVEMENT

When the Central Office Management Team (COMT) approves system design changes, the Quality Improvement Team monitors the implementation and analysis of the effectiveness of the design change. The Quality Improvement Team is a team comprised of the Bureau Chief, Quality Manager, Managers and Policy Staff.

It is the responsibility of the Quality Assurance Team to review QI processes and instruments through monthly conference calls (supported by team minutes) to oversee the day to day QI processes and report to the Quality Improvement Team. The Quality Assurance Team includes a Quality Manager, Managers and regional Quality Assurance Specialists. The Quality Assurance Team identifies and reports trends to The Quality Improvement Team and they are responsible for analyzing the effectiveness of existing quality designs and making targeted system improvements.

Quality Improvement Action Plans are reviewed by the Quality Improvement Team for approval, and a recommendation is sent to the COMT for direction regarding implementation.

The Department is evaluating and improving processes and systems on an ongoing basis. Each year the Department improves services to waiver participants by using the numerous data collection points, appropriate analysis and prioritization techniques, evaluation and feedback from various groups.

Annually, the Quality Improvement Strategy is reviewed by the Quality Assurance Team and Quality Improvement Team, and is then submitted to the Quality Oversight Committee and Bureau Leadership Team.

RESULTS & ANALYSIS

The following charts are organized by Waiver Assurance category and include the performance measure, the data collected (discovery), and the remediation/system improvements.

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I. LEVEL OF CARE (LOC) Determination

The State demonstrates that it implements the processes and instruments specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NR, or ICD/ID

Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
<p>a. 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.</p>	<p>Number and percent of SIB-R's completed on all applicants who request HCBS services.</p> <p>a. Numerator: number of SIB-R's completed. b. Denominator: number of applicants who requested HCBS services.</p> <p>NOTE: Not every participant requires a new SIB-R every year. The Numerator represents those participants who had a new SIB-R during the quarter (whether initial or annual). The denominator represents the total number of assessments completed during the quarter (both initial and annual) - whether or not a SIB-R was completed. Every participant represented in the denominator either had a new SIB-R completed during the quarter, or had a previous SIB-R reviewed by the Independent Assessment Provider to renew eligibility and to ensure the SIB-R still represents the current level of functioning of the participant.</p>	<p>The discovery method for this data is Contractor Reports</p> <p><u>2013 – Appendix A</u> 1848 SIB-R's completed 4518 applicants 41% Met</p> <p><u>2014 – Appendix B</u> 1759 SIB-R's completed 4649 applicants 38% Met</p> <p><u>2015 – Appendix C</u> 2149 SIB-R's completed 4928 applicants 44% Met</p>	<p>2013 - None Needed</p> <p>2014 - A new field was added to the ICDE database assessment tab which captures the date of the latest SIB-R and whether it was completed through a review, or a new SIB-R was administered.</p> <p>2015 - None Needed</p>

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	<p>Number and percent of initial applicants that meet ICF/ID LOC during the assessment process.</p> <p>a. Numerator: Number of initial applicants that meet ICF/ID LOC. b. Denominator: Number of initial applicants</p>	<p>The discovery method for this data is Contractor Reports</p> <p><u>2013 – Appendix A</u> 647 initial applicants that meet ICF/ID LOC 744 initial applicants 86 % Met</p> <p><u>2014- Appendix B</u> 606 initial applicants that meet ICF/ID LOC 718 initial applicants 84% Met</p> <p><u>2015- Appendix C</u> 630 initial applicants that meet ICF/ID LOC 770 initial applicants 82% Met</p>	<p>2013- None Needed- not all initial applications meet ICF/ID LOC</p> <p>2014- None Needed- not all initial applications meet ICF/ID LOC</p> <p>2015- None Needed- not all initial applications meet ICF/ID LOC</p> <p>NOTE: The difference in percentage each year refers to how many applicants were waiver vs state plan eligible. For example, in 2013 647 initial applicants met ICF/ID LOC out of 709 initial applications leaving 62 applicants who qualified for state plan services. Not all initial applicants meet ICF/ID LOC.</p>
	<p>Number and Percent of initial applicants that meet the needs-based State Plan HCBS eligibility during the assessment process.</p> <p>a. Numerator: Number of initial applicants that meet needs-based state plan HCBS eligibility b. Denominator: Number of initial applicants</p>	<p>The discovery method for this data is Contractor Reports</p> <p><u>2013 – Appendix A</u> 709 initial applicants that meet needs-based state plan HCBS eligibility 744 initial applicants 95 % Met</p> <p><u>2014- Appendix B</u> 653 initial applicants that meet needs-based state plan HCBS eligibility 718 initial applicants</p>	<p>2013- None Needed</p> <p>2014- None Needed</p> <p>2015- None Needed</p> <p>NOTE: The difference in percentage each year refers to how many applicants were waiver vs state plan eligible. For example, in 2015 698 initial applicants met at least the needs-based State Plan HCBS eligibility out of 770 initial applications. The remaining 72 applicants were denied eligibility for both State Plan and ICF/ID LOC.</p>

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		<p>91% Met 2015- Appendix C 698 initial applicants that meet needs-based state plan HCBS eligibility 770 initial applicants 91% Met</p>	
<p>b. The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.</p>	<p>Number and percent of participants who received an annual eligibility redetermination within 364 days of their previous LOC evaluation</p> <p>a. Numerator: Number of waiver participants who received an annual redetermination within 364 days of their previous LOC evaluation.</p> <p>b. Denominator: Number of waiver participants who received an annual redetermination.</p>	<p>The discovery method for this data is Contractor Reports</p> <p>2013 – Appendix A 3292 participants who received an annual redetermination 3388 waiver participants 97% Met</p> <p>2014 – Appendix B 3527 participants who received an annual redetermination 3540 waiver participants 99.6% Met</p> <p>2015 – Appendix C 3698 participants who received an annual redetermination 3822 waiver participants 97% Met</p>	<p>2013- Contract Monitor followed up with contractor to assure that any participants who went beyond the 364 day timeline were either determined eligible or closed.</p> <p>2014- Individuals who did not meet timelines have since been determined eligible by the contractor. Contract Monitor to work with contractor to develop reporting system to identify the reasons participants did not receive a renewal within the specified timeframe.</p> <p>2015- It was determined that 124 participants did not meet timelines and renew their plan within 364 days of their previous eligibility determination. All errors have since been corrected and eligibility has been determined. It was determined the contractor was not tracking timelines properly. They were previously tracking only errors that were their fault and not errors overall. Contract Monitor has instructed contractor to report all individuals not meeting timelines, and provide plans of correction going forward for situations where it was determined it was the fault of the contractor.</p>

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	<p>Number and percent of participants who received an annual redetermination of State Plan HCBS eligibility within 364 days of their previous eligibility evaluation.</p> <p>a. Numerator: Number of participants who received an annual redetermination of State Plan HCBS eligibility within 364 days of their previous eligibility evaluation.</p> <p>b. Denominator: Number of State Plan participants who received an annual redetermination</p>	<p>The discovery method for this data is Contractor Reports</p> <p>2013- Appendix A 410 participants who received an annual redetermination 421 State Plan participants 97% Met</p> <p>2014- Appendix B 373 participants who received an annual redetermination 376 State Plan participants 99% Met</p> <p>2015- Appendix C 328 participants who received an annual redetermination 350 State Plan participants 94% Met</p>	<p>2013- Through Contractor and Department Contract Monitor Reviews, it was determined that several individuals who went beyond the 364 day timeline were either still in the process of redetermination (late), or they had moved, or were not eligible, but had not been closed in the database. The Contract monitor followed up with the Contractor who, in turn, followed up with participants, to assure that any individuals who were beyond the 364 day timeline either received their annual eligibility determination, or were closed.</p> <p>2014- It was determined that 3 participants did not meet timelines and renew their plan within 364 days of their previous eligibility determination. All errors have since been corrected and eligibility has been determined.</p> <p>2015- It was determined that 22 participants did not meet timelines and renew their plan within 364 days of their previous eligibility determination. All errors have since been corrected and eligibility has been determined. Some errors were due to participants not attending eligibility appointments; the contractor has instituted a contact protocol to follow up before appointments to confirm appointment attendance.</p>
<p>c. The process and instruments described in the approved waiver are applied appropriately and according to the</p>	<p>Number and percent of sampled IAP Level of Care determinations eligibility criteria was determined appropriately.</p> <p>a. Numerator: number of sampled determinations where LOC was</p>	<p>The discovery method for this data is Contractor Reports</p> <p>2013 – Appendix A 389 LOC determined correctly 407 files audited</p>	<p>2013- It was determined that 18 participants had an error in the eligibility process; however none of the errors resulted in a participant being denied eligibility or vice versa. The Contractor has corrected eligibility process errors and re-trained staff.</p>

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<p>approved description to determine participant level of care.</p>	<p>determined appropriately. b. Denominator: number of sampled IAP LOC determinations (based on 95% confidence interval).</p>	<p>95% determined correctly</p> <p>2014 – Appendix B 521 LOC determined correctly 560 files audited 93% determined correctly</p> <p>2015 – Appendix C 489 LOC determined correctly 490 files audited 99.8% determined correctly</p>	<p>2014- It was determined that 39 participants had an error in the eligibility process; however none of the errors resulted in a participant being denied eligibility or vice versa. The Contractor has corrected any eligibility process errors and re-trained staff. In future reports, the Contractor will send the Department only errors that actually affect eligibility for QIS reporting purposes. Any errors that are reported will come with explanations as to the nature of the error, and any remediation/steps taken to correct the error.</p> <p>2015- It was determined that 1 participant had an eligibility error. It was discovered there was an error in having the appropriate documentation. The Psych evaluation used for eligibility was a WISC rather than a WAIS. The family has been contacted by the IAP and a new psych evaluation will be conducted.</p>
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II. SERVICE PLANS

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
<p>a. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.</p>	<p>Number and percent of service plans reviewed who had service plans that were adequate and appropriate to their needs (including health care needs) as indicated in the assessment(s).</p> <p>a. Numerator: number of plans reviewed that were adequate and appropriate to the participant's needs as indicated in the assessment. b. Denominator: number of plans reviewed (based on 95% representative sample)</p>	<p>The discovery method for this data is the Adult Services Outcome Reviews Appendix D Appendix DD Appendix E Appendix EE Appendix F</p> <p>2013- Appendix A 81 plans were appropriate 81 plans reviewed 100% Met</p> <p>2014- Appendix B 402 plans were appropriate 403 plans reviewed 99.8% Met</p> <p>2015- Appendix C 320 plans were appropriate 320 reviewed 100% Met</p>	<p>2013- None Needed</p> <p>2014- Vocation was listed as a need on the assessment, but not addressed on the plan. An enhanced review was conducted and the PCP team added vocational needs to participants' plan.</p> <p>2015- None Needed</p>
	<p>Number and percent of service plans that address participants' goals as indicated in the assessment(s).</p> <p>a. Numerator: number of service plans reviewed that address participants'</p>	<p>The discovery method for this data is the Adult Services Outcome Reviews Appendix D Appendix DD Appendix E</p>	<p>2013- None Needed</p> <p>2014- Enhanced Reviews were added to the process and were conducted for the participants whose plans did not address their personal goals</p>

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Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
	goals as indicated in the assessment. b. Denominator: number of service plans reviewed.	Appendix EE Appendix F 2013- Appendix A 81 plans address participants' goals 81 plans reviewed 100% Met 2014- Appendix B 383 plans address participants' goals 403 plans reviewed 95% Met 2015- Appendix C 318 plans address participants' goals 320 service plans reviewed 99% Met	2015- Enhanced reviews were conducted for the participants whose plans did not address their personal goals. Goals were adjusted as necessary to address personal goals.
	Number and percent of participant experience/satisfaction survey respondents who reported unmet needs (or unmet need in a given ADL, IADL or other area defined by the state). a. Numerator: number of participant experience/ satisfaction survey respondents who reported unmet needs. b. Denominator: number of participant	The discovery method for this data is the Participant Experience Surveys Appendix G 2013- Appendix A 66 participants reported unmet needs 737 respondents 9% reported unmet needs	2013- QA staff follows up with participants to ensure their needs are being met. Follow-up includes: Participant/guardian clarification and/or education; participant/guardian/provider referral to other resources; contact provider or member of the personal centered planning team; referral to Care Manager; Referral to Adult Protection or referral to Licensing and Certification program. 2014- QA staff follows up with participants to ensure their needs are met. Follow-up includes:

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	experience/ satisfaction survey respondents.	<p>2014- Appendix B 530 participants reported unmet needs 2293 respondents 23% reported unmet needs</p> <p>2015- Appendix C 59 participants reported unmet needs 2122 respondents 3% reported unmet needs</p>	<p>Participant/guardian clarification and/or education; participant/guardian/provider referral to other resources; contact provider or member of the personal centered planning team; referral to Care Manager; Referral to Adult Protection or referral to Licensing and Certification program. Survey staff followed up with each participant stating there were unmet needs. It was determined several questions were being misunderstood by participants. Adjustments were made to ensure participants had a good understanding of the questions. Additionally a field was also added for the Participant Experience Survey reporting to determine if follow-up that is conducted by QA staff is substantiated or not-substantiated.</p> <p>2015- QA staff follows up with participants to ensure their needs are met. Follow-up includes: Participant/guardian clarification and/or education; participant/guardian/provider referral to other resources; contact provider or member of the personal centered planning team; referral to Care Manager; Referral to Adult Protection or referral to Licensing and Certification program.</p>
b. The State monitors service plan development in	Number and percent of participants reviewed whose service plans had adequate and appropriate strategies to	The discovery method for this data is the Adult Services Outcome Reviews	<p>2013-None Needed</p> <p>2014-None Needed</p>

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Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
accordance with its policies and procedures.	<p>address their health and safety risks as indicated in the assessment(s).</p> <p>a. Numerator: number of participants reviewed whose plans had adequate and appropriate strategies to address their health and safety risks as indicated in the assessment.</p> <p>b. Denominator: number of participants reviewed.</p>	<p>Appendix D Appendix DD Appendix E Appendix EE Appendix F 2013- Appendix A 95 participants had appropriate strategies to address health and safety risks 95 plans reviewed 100% Met</p> <p>2014- Appendix B 403 participants had appropriate strategies to address health and safety risks 403 plans reviewed 100% Met</p> <p>2015- Appendix C 319 participants had appropriate strategies to address health and safety risks 320 plans reviewed 99.7% Met</p>	<p>2015- Agency was sent a remediation notice identifying areas determined to be out of compliance with and a request to correct any issues through their internal quality assurance review process. The identified areas will be specifically reviewed at their next quality assurance review.</p>

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Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
	<p>Number and percent of service plans reviewed that were submitted to the Department prior to the expiration of the current plan of service.</p> <p>a. Numerator: number of service plans reviewed that were submitted to the Department prior to the expiration of the current plan of service.</p> <p>b. Denominator: number of service plans reviewed.</p>	<p>The discovery method for this data is the Care Manager Reports</p> <p>2013- Appendix A 3083 plans submitted prior to the expiration date 3273 plans reviewed 94% of plans were submitted prior to the expiration date</p> <p>2014- Appendix B 3523 plans submitted prior to the expiration date 3397 plans reviewed 96% of plans were submitted prior to the expiration date</p> <p>2015- Appendix C 3617 plans submitted prior to the expiration date 3751 plans reviewed 96% of plans were submitted prior to the expiration date</p>	<p>2013- A process is being developed to reduce the number of late plans submitted to the Department by plan developers and support brokers. Late plans are a barrier to completing plan review and authorization in a timely manner. New process will assist with timely submission of plans. To ensure there was no gaps in service, participant plans were extended until new service plans could be put in place.</p> <p>2014- To further improve timely submission of plans a late plan notice for plan developers was implemented. If 5 or more plans are late in a quarter the plan developer is sent a plan of correction. To ensure there were no gaps in service, participant plans were extended until new plans could be put in place.</p> <p>2015- Modifications were made to the annual plan review report to reflect both plans due and plans received. Care Manager performance is based on plans actually received rather than comparing them to the total plans due. This is a more accurate assessment of performance. Corrections were also made to the incomplete and late plan report to show data should be run from the due date of the plan not the start date of the plan.</p>

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Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
<p>c. Service plans are updated/ revised at least annually or when warranted by changes in the waiver participants needs.</p>	<p>Number and percent of service plans that are updated/ revised when warranted by changes in the participant's needs/goals.</p> <p>a. Numerator: number of service plans that are updated/ revised when warranted by changes in the participant's needs/ goals.</p> <p>b. Denominator: number of service plans reviewed.</p>	<p>The discovery method for this data is the Adult Services Outcome Reviews</p> <p>Appendix D Appendix DD Appendix E Appendix EE Appendix F</p> <p>2013- Appendix A 93 plans updated/revised when warranted 93 plans reviewed 100% Met</p> <p>2014- Appendix B 413 plans updated/revised when warranted 413 plans reviewed 100% Met</p> <p>2015- Appendix C 320 plans updated/revised when warranted 320 plans reviewed 100% Met</p>	<p>2013- None Needed</p> <p>2014- None Needed</p> <p>2015- None Needed</p>

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Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
<p>d. Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan</p>	<p>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.</p> <p>a. Numerator: Number of plans reviewed that indicate services were delivered consistent with the approved plans.</p> <p>b. Denominator: Number of plans reviewed.</p>	<p>The discovery method for this data is the Adult Services Outcome Reviews</p> <p>Appendix D Appendix DD Appendix E Appendix EE Appendix F</p> <p>2013- Appendix A 145 plans reviewed that indicate services were delivered consistent with the approved plan 157 plans reviewed 92% Met</p> <p>2014- Appendix B 381 plans reviewed that indicate services were delivered consistent with the approved plan 430 plans reviewed 89% Met</p> <p>2015- Appendix C 308 plans reviewed that indicate services were delivered consistent with the approved plan 320 plans reviewed 96% Met</p>	<p>2013-Providers with deficiencies in this area were sent requests for plans of correction (POC). POC include: the corrective action taken; who will be responsible for the corrective action; how the corrective action will be monitored to ensure consistent compliance with IDAPA Code; dates the corrective action will be completed and what type of evidence or documentation will be provided to the Bureau of Developmental Disability Services documenting that the corrective action plan has been implemented. Once the POC is accepted by the Bureau of Developmental Disability Service providers have to submit documentation within 90 days demonstrating compliance.</p> <p>2014- An enhanced review was conducted for those plans that were not delivered consistent with the approved plan. Providers with deficiencies in this area were sent requests for remediation which includes the rule citations and a request to correct any issues through the agency's internal quality assurance process. These citations are then reviewed at the providers QA review. This change in the review process was a result of the information gathered through the Adult Services Outcome Review.</p> <p>2015- An enhanced review was conducted for</p>

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Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
			those plans that were not delivered consistent with the approved plan. Providers with deficiencies in this area were sent requests for remediation which includes the rule citations and a request to correct any issues through the agency's internal quality assurance process. These citations are then reviewed at the providers QA review.
e. Participants are afforded a choice: Between waiver services and institutional care; and between/among waiver services and providers.	<p>Number and percent of waiver service plans reviewed and approved that indicated the participant made a choice between waiver services and institutional care.</p> <p>a. Numerator: number of service plans reviewed and approved that indicated the participant made a choice between waiver services and institutional care.</p> <p>b. Denominator: number of service plans reviewed.</p>	<p>The discovery method for this data is Contractor Reports</p> <p>2013- Appendix A 4035 service plans reviewed and approved 4035 number of service plans reviewed 100% Met 4035 participants were determined eligible for the waiver services this year. Before each of the 4035 participants has a service plan approved by the Department, staff check to assure that the bottom of the plan of services is signed, accepting waiver services in lieu of placement in an ICF/ID.</p> <p>2014- Appendix B 926 plans indicated the participant</p>	<p>2013- Contractor to track exact number of files reviewed with service plan signature on file starting next waiver year.</p> <p>2014- It was noted that there were two plans without a choice between waiver services and institutional care. Department followed up with contractor to gather signature from the participant.</p> <p>2015- None needed</p>

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Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
		<p>made a choice between waiver services and institutional care 928 files reviewed 99.8% Met</p> <p>2015- Appendix C 893 plans indicated the participant made a choice between waiver services and institutional care 893 files reviewed 100% Met</p>	
	<p>Number and percent of participants reviewed who reported they were given a choice when selecting service providers.</p> <p>a. Numerator: number of participants reviewed who reported they were given a choice when selecting service providers. b. Denominator: number of participants reviewed.</p>	<p>The discovery method for this data is the Participant Experience Surveys Appendix G</p> <p>2013- Appendix A 688 participants who were given a choice when selecting service providers 737 participants reviewed 93% Met</p> <p>2014- Appendix B 1910 participants who were given a choice when selecting service providers 2293 participants reviewed</p>	<p>2013- QA staff follows up with participants who reported they were not given a choice to ensure their needs are being met.</p> <p>2014- QA staff follows up with participants to ensure their needs are being met. Follow-up includes: Participant/guardian clarification and/or education; participant/guardian/provider referral to other resources; contact provider or member of the personal centered planning team; referral to Care Manager; Referral to Adult Protection or referral to Licensing and Certification program. A field was also added to the Participant Experience Survey tracking if failure to offer choice is substantiated or unsubstantiated. This change was a result of participants reporting they marked the wrong box on the survey when QA staff conducted the</p>

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II. SERVICE PLANS

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
		<p>83% Met</p> <p>2015- Appendix C 1947 participants who were given a choice when selecting service providers 2122 participants reviewed 92% Met</p>	<p>follow up.</p> <p>2015- QA staff follows up with participants to ensure their needs are being met. Follow-up includes: Participant/guardian clarification and/or education; participant/guardian/provider referral to other resources; contact provider or member of the personal centered planning team; referral to Care Manager; Referral to Adult Protection or referral to Licensing and Certification program.</p>

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III. 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.

Sub Assurance	Performance Measure	Discovery	Remediation/System Improvement
a. The state verifies that providers initially and continually meet required licensure and /or certification standards and adhere to other state standards prior to their furnishing waiver services.	Number and percent of initial HCBS DD waiver providers that meet licensing/certification standards. a. Numerator: number of initial providers that meet required licensure or certification standards. b. Denominator: number of initial providers.	The discovery method for this data is the Licensing and Certification Reports 2013- Appendix A 200 initial providers meet required licensure or certification standards 200 initial providers 100% Met 2014- Appendix B 7 initial providers meet required licensure or certification standards 7 initial providers 100% Met 2015- Appendix C 7 initial providers meet required licensure or certification standards 7 initial providers 100% Met	2013- None Needed 2014- None Needed 2015- None Needed
	Number and percent of ongoing HCBS DD waiver providers who meet licensing/certification standards. a. Numerator: number of ongoing providers that meet required licensure or certification standards. b. Denominator: number of ongoing	The discovery method for this data is the Licensing and Certification Reports 2013- Appendix A 991 providers that meet licensure or certification standards 998 ongoing providers	2013- Issued provisional certification and required plans of correction from agencies that did not meet standards 2014- Issued provisional certification and required plans of correction from agencies that did not meet standards

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III. 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.

Sub Assurance	Performance Measure	Discovery	Remediation/System Improvement
	providers.	<p>99% Met</p> <p>2014- Appendix B 552 providers that meet licensure or certification standards 561 ongoing providers 98% Met</p> <p>2015- Appendix C 406 providers that meet licensure or certification standards 406 ongoing providers 100% Met</p>	<p>2015- None Needed</p>
<p>b. The State monitors non-licensed/non-certified providers to assure adherence to provider standards</p>	<p>Number and percent of new providers that have an initial provider review within 6 months of providing services to participants.</p> <p>a. Numerator: number of initial providers who have a review within 6 months of providing services to waiver participants.</p> <p>b. Denominator: number of initial providers.</p>	<p>The discovery method for this data is the Provider Quality Assurance Reviews</p> <p>2013- Appendix A 5 initial providers who had a review within 6 months of providing services 6 initial providers reviewed 83% Met</p> <p>2014- Appendix B 13 initial providers who had a review within 6 months of providing services 15 initial providers reviewed 87% Met</p>	<p>2013- Education and re-training was provided to Department staff to ensure QA reviews are conducted timely</p> <p>2014- Education and re-training was provided to Department staff to ensure QA reviews are conducted timely. Some of the QA reviews were conducted late as a result of scheduling conflicts with providers. The reviews had to be rescheduled.</p> <p>2015- None Needed</p>

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III. 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.

Sub Assurance	Performance Measure	Discovery	Remediation/System Improvement
		<p>2015- Appendix C 5 initial providers who had a review within 6 months of providing services 5 initial providers reviewed 100% Met</p>	
	<p>Number and percent of HCBS DD waiver providers who received an on-site review every two years.</p> <p>a. Numerator: number of providers who received an on-site review every two years. b. Denominator: number of providers.</p>	<p>The discovery method for this data is the Provider Quality Assurance Reviews</p> <p>2013- Appendix A 29 providers received an on-site review every two years 37 providers reviewed 78% Met</p> <p>2014- Appendix B 56 providers received an on-site review every two years 64 providers reviewed 87% Met</p> <p>2015- Appendix C 36 providers received an on-site review every two years 37 providers reviewed 97% Met</p>	<p>2013- Education and re-training was provided to Department staff to ensure QA reviews are conducted timely</p> <p>2014- Education and re-training was provided to Department staff to ensure QA reviews are conducted timely. Some of the QA reviews were conducted late as a result of scheduling conflicts with providers. The reviews had to be rescheduled.</p> <p>2015- Education and re-training was provided to Department staff to ensure QA reviews are conducted timely. Some of the QA reviews were conducted late as a result of scheduling conflicts with providers. The reviews had to be rescheduled.</p>

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III. 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.

Sub Assurance	Performance Measure	Discovery	Remediation/System Improvement
<p>c. The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.</p>	<p>Number and percent of DD waiver direct care staff that meet state requirements for training.</p> <p>a. Numerator: number of staff reviewed that meet state requirements for training.</p> <p>b. Denominator: number of staff reviewed.</p>	<p>The discovery method for this data is the Provider Quality Assurance Reviews and Licensing and Certification Reports</p> <p>2013- Appendix A 87 staff reviewed that meet state requirements for training 122 staff reviewed 71% Met</p> <p>2014- Appendix B 96 staff reviewed that meet state requirements for training 142 staff reviewed 68% Met</p> <p>2015- Appendix C 167 staff reviewed that meet state requirements for training 210 staff reviewed 79% Met</p>	<p>2013- Providers with deficiencies in this area were sent requests for plans of correction. POC include: the corrective action taken; who will be responsible for the corrective action; how the corrective action will be monitored to ensure consistent compliance with IDAPA Code; dates the corrective action will be completed and what type of evidence or documentation will be provided to the Bureau of Developmental Disability Services documenting that the corrective action plan has been implemented</p> <p>2014- Providers with deficiencies in this area were sent requests for plans of correction. POC include: the corrective action taken; who will be responsible for the corrective action; how the corrective action will be monitored to ensure consistent compliance with IDAPA Code; dates the corrective action will be completed and what type of evidence or documentation will be provided to the Bureau of Developmental Disability Services documenting that the corrective action plan has been implemented.</p> <p>2015- Providers with deficiencies in this area were sent requests for plans of correction. POC include: the corrective action taken; who will be responsible for the corrective action; how the corrective action will be monitored to ensure consistent compliance with IDAPA Code; dates</p>

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III. 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.

Sub Assurance	Performance Measure	Discovery	Remediation/System Improvement
			the corrective action will be completed and what type of evidence or documentation will be provided to the Bureau of Developmental Disability Services documenting that the corrective action plan has been implemented.
	<p>Number and percent of participants who have the opportunity to provide feedback to the Department regarding Medicaid HCBS providers.</p> <p>a. Numerator: number of participants who have the opportunity to provide feedback to the Department regarding providers. b. Denominator: number of participants receiving services.</p>	<p>The discovery method for this data is the Participant Experience Surveys Appendix G</p> <p>2013- Appendix A 737 participants who have the opportunity to provide feedback 737 participants receiving services 100% Met</p> <p>2014- Appendix B 3562 participants who have the opportunity to provide feedback 3562 participants receiving services 100% Met</p> <p>2015- Appendix C 4140 participants who have the opportunity to provide feedback 4140 participants receiving services 100% Met</p>	<p>2013- None Needed</p> <p>2014- None Needed</p> <p>2015- None Needed</p>

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IV. HEALTH & WELFARE			
On an on-going basis the state identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.			
Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
<p>The State demonstrates on an ongoing basis that it identifies addresses and seeks to prevent instances of abuse, neglect and exploitation.</p>	<p>Number and percent of service plans reviewed that address potential and real risks and had back up plans are in place as needed.</p> <p>a. Numerator: Number of plans reviewed that address potential and real risks and back up plans are in place as needed.</p> <p>b. Denominator: Number of service plans reviewed.</p>	<p>The discovery method for this data is the Adult Services Outcome Reviews Appendix D Appendix DD Appendix E Appendix EE Appendix F</p> <p>2013- Appendix A 93 plans reviewed that address potential and real risks and back up plans are in place 93 plans reviewed 100% Met</p> <p>2014- Appendix B 413 plans reviewed that address potential and real risks and back up plans are in place 413 plans reviewed 100% Met</p> <p>2015- Appendix C 319 plans reviewed that address potential and real risks and back up plans are in place 320 plans reviewed 99.7% Met</p>	<p>2013- None Needed</p> <p>2014- None Needed</p> <p>2015- Check box was missed for one of the plans. QA staff followed up with the Care Manager and this was fixed.</p>

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IV. HEALTH & WELFARE			
On an on-going basis the state identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.			
Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
	Number and percent of complaints reported by participants or others. a. Numerator: Number of complaints reported by participants or others b. Denominator: Number of complaints reported	The discovery method for this data is the Complaint and Critical Incident Reports 2013- Appendix A 65 complaints were investigated 65 complaints reported 100% Met 2014- Appendix B 47 complaints were investigated 47 complaints reported 100% Met 2015- Appendix C 112 complaints of were investigated 112 complaints reported 100% Met	2013- None Needed 2014- None Needed 2015- None Needed
	Number and percent of substantiated complaints. a. Numerator: Number of substantiated complaints b. Number of substantiated complaints	The discovery method for this data is the Complaint and Critical Incident Reports 2013- Appendix A 48 substantiated complaints were	2013- None Needed 2014- None Needed 2015- None Needed

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IV. HEALTH & WELFARE			
On an on-going basis the state identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.			
Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
	reported.	<p>remedied 48 substantiated complaints reported 100% Met</p> <p>2014- Appendix B 26 substantiated complaints were remedied 26 substantiated complaints reported 100% Met</p> <p>2015- Appendix C 63 substantiated complaints were remedied 63 substantiated complaints reported 100% Met</p>	
	<p>Number and percent of critical incidents related to abuse, neglect and exploitation.</p> <p>a. Numerator: Number of critical incidents related to abuse, neglect and exploitation that are investigated. b. Number of critical incidents reported</p>	<p>The discovery method for this data is the Complaint and Critical Incident Reports</p> <p>2013- Appendix A 48 incidents related to abuse, neglect and exploitation that are investigated 48 critical incidents reported 100% Met</p> <p>2014- Appendix B 74 incidents related to abuse, neglect and exploitation that are investigated 74 critical incidents reported 100% Met</p>	<p>2013- None Needed</p> <p>2014- None Needed</p> <p>2015- None Needed</p>

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IV. HEALTH & WELFARE			
On an on-going basis the state identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.			
Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
		2015- Appendix C 147 incidents related to abuse, neglect and exploitation that are investigated 147 critical incidents reported 100% Met	
	Number and percent of substantiated critical incidents related to abuse, neglect, and exploitation with remediation. a. Numerator: Number of substantiated critical incidents related to abuse, neglect and exploitation that were remedied. b. Number of substantiated critical incidents	The discovery method for this data is the Complaint and Critical Incident Reports 2013- Appendix A 27 substantiated critical incidents related to abuse, neglect and exploitation that were remedied 27 substantiated critical incidents 100% Met 2014- Appendix B 41 substantiated critical incidents related to abuse, neglect and exploitation that were remedied 41 substantiated critical incidents 100% Met 2015- Appendix C 71 substantiated critical incidents related to abuse, neglect and exploitation that were remedied 71 substantiated critical incidents 100% Met	2013- None Needed 2014- None Needed 2015- None Needed

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IV. HEALTH & WELFARE			
On an on-going basis the state identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.			
Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
	<p>Number and percent of participant (and/or family or legal guardian) who received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver.</p> <p>a. Numerator: Number of participants (and/or family or legal guardian) who received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver</p> <p>b. Number of assessments completed</p>	<p>The discovery method for this data is Contractor Reports</p> <p>2013- Appendix A At each person centered planning meeting, participants are given information/education on how to report abuse, neglect and exploitation. The eligibility contractor is also distributing this information at each assessment appointment as part of the initial/annual eligibility process. However, no formal tracking occurred to demonstrate exactly how many participants received this information. The eligibility contractor will begin tracking this information next waiver year.</p> <p>2014- Appendix B 4023 participants received information/education about how to report abuse, neglect, exploitation and other critical incidents 4623 assessments completed 87% Met</p> <p>2015- Appendix C 4803 participants received information/education about how to report abuse, neglect, exploitation</p>	<p>2013- Eligibility contractor to track this data starting next waiver year.</p> <p>2014- The eligibility contractor started tracking the number of maltreatment handouts distributed partway through the first quarter, which explains the discrepancy in numbers. The Contractor has since followed up and distributed maltreatment information to all participants that were missed.</p> <p>2015- Contractor was retrained on distribution of maltreatment information. Participants who did not initially receive the maltreatment information were sent the handouts.</p>

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IV. HEALTH & WELFARE			
On an on-going basis the state identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.			
Sub Assurances	Performance Measure	Discovery	Remediation/System Improvement
		and other critical incidents 4835 assessments completed 99.3% Met	

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V. 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

Sub Assurance	Performance Measure	Discovery	Remediation/System Improvement
<p>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.</p>	<p>Number and percent of remediation issues identified in the QIS performance reports that were followed up on and monitored through QIS reporting.</p> <p>a. Numerator: Number of remediation issues followed up on and monitored through QIS reporting.</p> <p>b. Denominator: Number of remediation issues identified in the QIS performance reports.</p>	<p>The discovery method for this data is Contractor Reports</p> <p>2013- Appendix A -Appendix AA No remediation issues were identified from the Independent Assessment Provider contract or the Residential Habilitation Program Coordination Contract</p> <p>2014- Appendix B -Appendix AA No remediation issues were identified from the Independent Assessment Provider contract or the Residential Habilitation Program Coordination Contract</p> <p>2015- Appendix C -Appendix AA 23 issues were identified in the QIS performance reports 23 issues were followed up on and monitored through the QIS reporting 100% Met</p>	<p>2013- None Needed</p> <p>2014- None Needed</p> <p>2015- 23 files reviewed by the contract had minor errors. All issues have been corrected/followed up on by the contractor and/or contract monitor. The ICDE contract monitor reviews random files. On a quarterly basis the contract monitor will submit a report to the contactor identifying any errors discovered during the review. The contractor has 10 days to respond and correct any errors and develop a department approved plan of correction if necessary.</p>

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V. 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

Sub Assurance	Performance Measure	Discovery	Remediation/System Improvement
		<p>MMCP Contract The Idaho Department of Health and Welfare maintains authority and oversight over the health plan's administration of DD Waiver services and functions. The MMCP Scope of Work detailing the health plan's responsibilities in administering DD Waiver services can be located at http://healthandwelfare.idaho.gov/Portals/0/Medical/Managed%20Care/MMCPScopeOfWork2015-2016.pdf</p>	

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VI. FINANCIAL ACCOUNTABILITY

The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program

Sub Assurance	Performance Measure	Discovery	Remediation/System Improvement
<p>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</p>	<p>In the aggregate, the cost of services on the waiver does not exceed the average cost of ICF/ID services indicated in the most recently submitted 372 report.</p> <p>a. Numerator: aggregate cost of services on the waiver. b. Denominator: average cost of ICF/ID services indicated in the most recently submitted 372 report.</p>	<p>The discovery method for this data is the CMS-372 Reports</p> <p>2013- Appendix A \$38,516 aggregate cost of services on the waiver \$90,797 average cost of ICF/ID services</p> <p>2014- Appendix B \$40,666 aggregate cost of services on the waiver \$92,871 average cost of ICF/ID services</p> <p>2015- Appendix C Amounts have not yet been reported</p>	<p>2013- None Needed</p> <p>2014- These amounts are not final or approved. Providers have up to a year to bill for services provided.</p> <p>2015- Amounts have not yet been reported</p>
	<p>Number and percent of demonstrated service provider's fraudulent billing patterns investigated by IDHW and action taken.</p> <p>a. Numerator: number of demonstrated waiver service provider's fraudulent billing patterns in which action was taken. b. Denominator: number of demonstrated waiver service provider's fraudulent billing patterns investigated by IDHW.</p>	<p>The discovery method for this data is based on reports of fraud that are substantiated through the State of Idaho Medicaid Fraud Control Unit.</p> <p>2013- Appendix A No providers had fraudulent billing during this year</p> <p>2014- Appendix B No providers had fraudulent billing during this year</p>	<p>2013- None Needed</p> <p>2014- None Needed</p> <p>2015- None Needed</p>

VI. FINANCIAL ACCOUNTABILITY

The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program

Sub Assurance	Performance Measure	Discovery	Remediation/System Improvement
		2015- Appendix C No providers had fraudulent billing during this year	