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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Idaho Developmental Disabilities Waiver (renewal)

C. Waiver Number: ID.0076
Original Base Waiver Number: ID.0076.90.R3B

D. Amendment Number: [ID.0076.R06.01]

E. Proposed Effective Date: *(mm/dd/yy)*
05/01/2018
Approved Effective Date of Waiver being Amended: 10/01/2017

2. Purpose(s) of Amendment

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

Character Count: 485 out of 12000

The purposes of this amendment to Idaho's Developmental Disabilities Waiver are as follows:

1. To revise the reimbursement methodology information for residential habilitation services (Appendix I-2-a); and

2. To revise the Composite Overview and Demonstration of Cost-Neutrality Formula (Appendix J-1) and the Estimate of Factor D tables for Waiver Years 1-5 (Appendix J-2-d) to reflect updated residential habilitation service rates based on the revised reimbursement methodology.

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3. Nature of the Amendment

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

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

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

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

Specify:

Character Count: 146 out of 6000

To revise financial accountability provisions regarding the methods and standards for setting payment rates for residential habilitation services.

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

[Sections Omitted]

6. Additional Requirements

[Sections Omitted]

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

Character Count: 5828 out of 6000

Idaho has well-established provider, advocate, and participant associations that provide frequent feedback to the Department regarding our programs for people with developmental disabilities, including the DD waiver program. Whenever changes to the waiver are considered by the Department, we solicit input from these associations as well as other potentially affected stakeholders.

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

The Department solicited meaningful public input for this waiver amendment as follows:

First Round of Solicitation in Connection with Proposed Amendment to Waiver (ID.0076.R05)

1. Department contracted with an independent accounting firm to perform a cost survey of residential habilitation providers. Process and results of cost survey can be found at http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/SupportedLivingReport.pdf.

2. Department sent written notice and request for comment on proposed waiver amendment to designated tribal representatives of Idaho's 6 federally recognized tribes on August 12, 2016. Department received no comments from Tribal representatives.

3. During October 2016, Department sent written notification and request for comment on proposed waiver amendment to providers and participants.

4. Department held a public hearing on October 24, 2016 to discuss results of cost survey with stakeholders.

5. On November 15 and 16, 2016, Department published public notice of proposed waiver amendment in newspaper of widest circulation in each Idaho city with population of 50,000 or more and on the internet at http://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx (Department's website). Copies of public notice and proposed waiver amendment were made available for public review on Department's website and during regular business hours at specified agency locations in each Idaho county. The public was given the opportunity to comment on the proposed waiver amendment for a period of at least 30 days.

6. Department held a public hearing on November 29, 2016 for individuals to provide oral comment on proposed waiver amendment.

7. Department received a total of 32 timely comments. The Department did not make changes to its waiver amendment based on the comments received. A document summarizing comments received and Department's responses was posted on Department's website and sent to CMS with a copy of all written comments received.

Second Round of Solicitation in Connection with Waiver Renewal Application (ID.0076.R06)

1. Department sent written notice of proposed waiver renewal on March 9, 2017 and a second notice soliciting comment regarding proposed waiver renewal on April 25, 2017 to designated tribal representatives of the 6 federally recognized tribes in Idaho. Department received no comments from Tribal representatives.

2. On April 25, 2017, Department published public notice of proposed waiver renewal in newspapers of widest circulation in each Idaho city with a population of 50,000 or more and on Department's website. Copies of public notice and the proposed waiver renewal were made available for public review on Department's website and during regular business hours at the Medicaid Central Office and the seven regional Medicaid services offices. The public was given opportunity to comment on proposed waiver renewal for a period of at least 30 days.

3. During May 2017, Department held public hearings in each of its 3 regional hubs for individuals to provide oral comment on proposed waiver renewal.

4. Department received a total of 13 timely comments. Department did not make changes to its waiver renewal application based on comments received. A document summarizing the comments received and Department's responses was posted on Department's website and sent to CMS with a copy of all written comments received.

5. At stakeholders' request, Department surveyed providers to identify number of high-supports participants served by one direct care staff person at one time. Results of ratio survey were used to extrapolate residential habilitation base rate into an appropriate group support service rates.

Third Round of Solicitation in Connection with this Proposed Waiver Amendment (ID.0076.R06)

1. Department sent written notice of the anticipated waiver amendment on October 27, 2017 and a second notice soliciting comment regarding proposed waiver amendment on [November 28, 2017] to designated tribal representatives of the 6 federally recognized tribes in Idaho. The Department received [##] comments from Tribal representatives.

2. On [November 28, 2017], Department published public notice of proposed waiver amendment in newspapers of widest circulation in each Idaho city with a population of 50,000 or more and on Department's website. Copies of public notice and proposed waiver amendment were made available for public review on Department's website and during regular business hours at specified agency locations in each Idaho county. The public was given opportunity to comment on proposed waiver amendment for a period of at least 30 days.

3. During December 2017, Department will hold public hearings in each of its 3 regional hubs for individuals to provide oral comment on proposed waiver amendment.

4. A document summarizing the comments received and Department's responses will be posted on Department's website.

[Sections Omitted]

[Sections Omitted]

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

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

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

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

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

Character Count: 50520 out of 60000

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

Idaho assures that the setting transition plan included with this waiver will be subject to any provisions or requirements in the State's approved Statewide Transition Plan. The State will implement any applicable required changes upon approval of the Statewide Transition Plan and will make conforming changes to this waiver, as needed, when it submits the next amendment or renewal. The most recent version of the Statewide Transition Plan can be found at www.hcbs.dhw.idaho.gov.

Overview

The intention of the home and community-based services (HCBS) rule is to ensure individuals receiving long-term services and supports through these waiver programs have full access to the benefits of community living and the opportunity to receive services in the most integrated settings appropriate. In addition, the new regulations aim to enhance the quality of HCBS and provide protections to participants.

Idaho Medicaid initiated a variety of activities beginning in July of 2014 designed to engage stakeholders in the development of this Transition Plan. The engagement process began with a series of web-based seminars that were hosted in July through September 2014 and which summarized the new regulations and solicited initial feedback from a wide variety of stakeholders. A second series of web-based seminars as well as conference calls were launched in April, 2016 and continued through December, 2016. HCBS providers, participants, and advocates were invited to attend these seminars. The state also launched an HCBS webpage, www.HCBS.dhw.idaho.gov hosting information about the new regulations, FAQs, and updates regarding the development of Idaho's draft Transition Plan. The webpage contains an "Ask the Program" feature whereby interested parties are encouraged to submit comments, questions, and concerns to the project team at any time. Additional opportunities were established to share information

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and for stakeholders to provide input regarding the new regulations and Idaho's plans for transitioning into full compliance. They are described in more detail throughout this document.

The Statewide Transition Plan includes:
- A description of the work completed to date to engage stakeholders in this process;
- A systemic assessment of existing support for the new HCBS regulations;
- A plan for systemic remediation;
- A plan for assessment of all residential and non-residential service settings;
- A plan for provider remediation;
- A plan for relocation of impacted participants;
- A plan for on-going monitoring of all HCBS service settings;
- A timeline for remaining activities to bring Idaho into full compliance;
- A summary of public comments; and
- An index of changes made in version three of the Transition Plan.

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

Additional changes to the body of Transition Plan (v3) were made prior to it being posted on September 11, 2015 and again on June 3, 2016. These changes incorporate updated information; include new details; and, in some instances, add clarifying information. All changes are noted in the Index of Changes (Attachment7).

Section 1: Systemic Assessment and Systemic Remediation

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

Please note two things about the systemic assessment of existing support:
1. Idaho looked for existing support for each HCBS requirement to begin the gap analysis. If any support was found, that information was documented in the support row in the gap analysis tables. However, a reference to identified support DOES NOT necessarily mean the requirement is fully supported by the rule(s) cited. In some instances the rule support that was cited only partially supported the requirement and thus additional rule changes are noted in the remediation strategy. For example, IDAPA currently requires residential providers to offer residents three meals a day. The state considers this to be support for the requirement that individuals have access to food at any time, but only partial support. A number of the citations in the "support" column are from Licensing and Certification rules – Medicaid rules set a higher standard for those licensed and certified providers that serve Medicaid participants. Thus, the state identified that additional changes to IDAPA were needed.
2. Idaho acknowledges that this gap analysis is only the first step in the assessment process. It has been used to identify where Idaho lacks documented support for the setting quality requirements. Idaho understands that more work is necessary to complete a full assessment of settings. Section Three of this document identifies the work remaining to complete a thorough assessment. That process includes soliciting input from individuals who live in and use these settings, provider self-assessment, as well as on-site assessment of compliance.

The results of the gap analysis of residential settings were shared with stakeholders via a WebEx meeting on September 16, 2014. The results of the gap analysis of non-residential settings were shared with stakeholders via a WebEx meeting on January 14, 2015. The WebEx presentations and audio recordings were then posted on the Idaho

HCBS webpage. This preliminary analysis has informed the recommendation to develop several changes to rule, operational processes, quality assurance activities, and program documentation.

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

Service settings for the Adult's Developmental Disabilities Waiver include: Developmental Disability Agencies (DDAs), Certified Family Homes (CFHs), Adult Day Health Centers, private homes, or the community. The tables detailing Idaho's waiver services and the service settings in which those services may occur are located at: http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=9

1a. Systemic Assessment of Residential Settings

The Adult's Developmental Disabilities waiver offers HCBS services in one type of provider owned or controlled residential settings: Certified Family Homes (CFHs). The results of Idaho's analysis of these residential settings are summarized below and in the table (which includes an overview of existing support for each regulation) located at: http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=13. The state has included, where applicable, the full IDAPA citations to identify where IDAPA supports the HCBS requirement, in addition to indicating if IDAPA is silent. The state did not identify any IDAPA provision that conflicts with the HCBS requirements. Additionally, the table includes preliminary recommendations on how to transition these settings into full compliance with the new regulations.

In summary, the state determined that there were gaps in support for some of the HCBS setting qualities in CFHs. Identified gaps included: lack of standards, lack of IDAPA support, and lack of oversight/monitoring to ensure compliance. Planned remediation activities include: development of best practices to address access "to the same degree as individuals not receiving Medicaid HCBS;" rule promulgation to incorporate support for HCBS setting qualities into IDAPA; and enhanced monitoring and quality assurance activities to ensure ongoing compliance.

Please note that the analysis of existing support for each new regulation is only the first step in the assessment process. It has been used to identify where Idaho lacks documented support for the setting quality requirements. Idaho understands that more work is necessary to complete a full assessment of settings. "Section 3: Site-Specific Assessment and Site-Specific Remediation" identifies the work remaining to complete a thorough assessment. That process includes soliciting input from individuals who live in and use these settings, provider self-assessment, as well as on-site validation of compliance.

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

Non- Provider Owned or Controlled Residential Settings

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

As part of Idaho's outreach and collaboration efforts, Medicaid initiated meetings with supported living service providers in September 2014. The goal of these meetings was to ensure that supported living providers understood the new HCBS setting requirements, how the requirements will apply to the work that they do, and to address any

questions or concerns this provider group may have. During these meetings, providers expressed concern regarding how the HCBS setting requirements would impact their ability to implement strategies to reduce health and safety risks to participants receiving high and intense supports in their own homes. Because of these risk reduction strategies, supported living providers are concerned that they will be unable to ensure that all participants receiving supported living services have opportunities for full access to the greater community and that they are afforded the ability to have independence in making life choices.

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

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

1b. Systemic Assessment of Non-Residential Service Settings

Idaho completed a preliminary gap analysis of its non-residential service settings in December 2014. The results of Idaho's analysis of its non-residential settings are summarized below and in the table (which includes an overview of existing support for each regulation) located at: http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=23. The state has included, where applicable, the full IDAPA rule citation(s) to identify where IDAPA supports the HCBS requirement, in addition to indicating if IDAPA is silent. The state did not identify any IDAPA rule that conflicts with the HCBS requirements. Additionally, the table includes preliminary recommendations to transition these settings into full compliance with the new regulations.

In summary, the state determined that there were gaps in support for some of the HCBS setting qualities for some of Idaho's non-residential services. Identified gaps included: lack of standards, lack of IDAPA support, and lack of oversight/monitoring to ensure compliance. Planned remediation activities include: development of standards to address congregate settings; development of best practices to address access "to the same degree as individuals not receiving Medicaid HCBS;" rule promulgation to incorporate support for HCBS setting qualities into IDAPA; and enhanced monitoring and quality assurance activities to ensure ongoing compliance. The Adult's Developmental Disabilities waiver services analyzed included: Supported Employment, Residential Habilitation – Supported Living, and Adult Day Health. These services may occur in Developmental Disability Agencies, Adult Day Health Centers, a private home, or the community.

Please note that the analysis of existing support for each new regulation is only the first step in the assessment process. It has been used to identify where Idaho lacks documented support for the setting quality requirements. Idaho understands that more work is necessary to complete a full assessment of settings. Section Three of this document identifies the work remaining to complete a thorough assessment. That process includes soliciting input from participants receiving services, provider self- assessment, as well as on-site assessment of compliance.

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

1c. Systemic Remediation

Idaho identified several tasks required for systemic remediation, including promulgating administrative rule to incorporate the HCBS setting qualities, enhancing existing monitoring and quality assurance activities, revising operational processes, development of best practice for same degree of access, and implementing operational changes. The table containing the systemic remediation tasks, timeline, and status is located at:

http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=38

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

It should be noted that Idaho follows a very prescriptive process of negotiated rulemaking and public noticing when promulgating IDAPA rules. For these changes the public was notified about upcoming regulatory changes in a variety of formats: the Department posted proposed changes, hosted various in-person and video conference meetings with the public to discuss changes, accepted comments on proposed rule language on more than one occasion, documented those comments and modified rule language based on public comment. Information on upcoming rule changes was also published on the Idaho HCBS webpage with details on how to comment. In addition the STP published for comment in October 2014, the STP published for comment in January 2015 and the STP published for comment in September 2015 all identified that rules would be promulgated in the 2016 legislative session.

1d. Services Not Selected for Detailed Analysis

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

For the Adult's Developmental Disabilities Waiver, the services not selected for detailed analysis include:
- Chore Services
- Environmental Accessibility Adaptations
- Home Delivered Meals
- Personal Emergency Response System
- Skilled Nursing
- Specialized Medical Equipment and Supplies
- Non-Medical Transportation
- Behavior Consultation/Crisis Management
- Community Support Services
- Financial Management Services
- Support Broker Services; and
- Respite

Section 2: Analysis of Settings for Characteristics of an Institution

The Centers for Medicare and Medicaid Services has identified three characteristics of settings that are presumed to be institutional. Those characteristics are:
1. The setting is in a publicly or privately owned facility providing inpatient treatment.
2. The setting is on the grounds of, or immediately adjacent to, a public institution.
3. The setting has the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS.

Idaho completed an initial assessment of all settings against the first two characteristics of an institution in early 2015. At that time, there were no settings where an HCBS participant lived or received services that were located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment. Further, there were no settings on the grounds of or immediately adjacent to a public institution.
Idaho has initiated its assessment of all settings for the third characteristic on an institutional setting: the setting has the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS. That process is described in detail in Section 2a and Section 2b.

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

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

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

The Adult's Developmental Disabilities waiver supports one residential setting that needed to be analyzed against the characteristics established by CMS as presumptively institutional: Certified Family Homes.

Certified Family Homes (CFHs)

In September of 2014 Department of Health and Welfare's health facility surveyors from the CFH program were asked to identify if any CFH was in a publicly or privately owned facility providing inpatient treatment, or on the grounds of or immediately adjacent to a public institution. Health Facility surveyors visit every CFH once a year so they have intimate knowledge of each physical location. No CFH was found to meet either of the first two characteristics of an institution. In April 2016 that process was repeated with questions added related to isolation. Surveyors again reported that there are no CFHs that are in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. However, six CFHs were identified as potentially having the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS.

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

Idaho's non-residential HCB services by definition must occur in a participant's private residence, the community, in developmental disabilities agencies (DDAs) or in standalone adult day health centers. A setting in a participant's private residence or the community is presumed to be compliant with all HCBS requirements. For the non-residential service setting analysis, DDAs and adult day health centers were the two setting types examined.

In 2015 Medicaid solicited the help of Department of Health and Welfare staff responsible for completing the licensing and certification of DDA settings to assess those settings for the first two characteristics of an institution. Those characteristics are that they are in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. A list of all DDAs was created with two questions tied to the two above mentioned characteristics of an institutional setting. Licensing and certification staff who routinely visit those settings then answered the two questions about each specific DDA. No DDAs were found to be in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. In April 2016 that process was repeated with questions added related to isolation. No DDAs were found to have any of the three characteristics of an institution.

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

2c. This subsection of the STP related to Children's Residential Care Facilities is not applicable to Adults with Developmental Disabilities and was therefore omitted from this summary for the Adult's Developmental Disabilities waiver.

2d. Heightened Scrutiny Process

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

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

The review of settings with a negative or 'unknown' response to the questions assessing the characteristics of an institution will be completed by June 30, 2017. Idaho will identify those settings it believes can overcome the assumption of being institutional and will submit evidence to CMS demonstrating such. This evidence will include such things as:
• Any documented procedures for how individuals access the broader community
• Logs which may be used for exiting or entering the setting
• Case notes on individual's activities
• Calendar of activities sponsored outside of the setting
• Documented procedures for outside visitors and outside phone calls, etc.

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

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

Overview

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

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

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

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

The assessment plan described below in 3a covers provider owned or controlled residential and non-residential settings that are not the participants' own home. These are settings in which providers have the capacity to influence setting qualities. The provider types and number of current setting are:
• Adult Day Health Centers – 53 service sites
• Developmental Disability Agencies – 75 service sites

• Certified Family Homes – 2,212 service sites

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

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

Idaho Standards for Integration in All Settings

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

Initially, Idaho intended to create standards for integration for both residential and non-residential HCBS settings. The goal was to ensure that stakeholders, providers, quality assurance/assessment staff and participants, understood what must occur in HCB service settings to meet the integration and choice requirements of the new regulations. After many meetings with stakeholders, standards were determined for residential settings. However, that task was more of a challenge for non-residential service settings. The services themselves are variable and many are clinical in nature. Idaho organized a series of meetings with stakeholders to discuss what standards for non-residential service settings should be.

Ultimately it was determined that instead of having fixed standards for integration, a toolkit will be developed for providers that includes guidelines, instructions for completing a self-assessment, review criteria and best practices for integration. The guidance will be incorporated into all trainings for staff and providers. It will also be incorporated into the setting assessment to be completed in 2017 and be part of ongoing monitoring of these settings. Attachments 1 and 2 have thus been removed from the Transition Plan (v3). It is the state's intention to ensure that any self-assessment tool or documents developed as part of the toolkit appropriately assess if participants are or are not given the opportunity for community participation to the extent that they desire and in manner that they desire in that setting.

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

3a. Site-Specific Assessment

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

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

The proposed strategy and timeline for assessment includes the following activities:

1. Baseline Assessment of Settings: April 2016 – June 2016

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

2. Provider Self-Assessment: August 1, 2016 – December 31, 2016

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

3. Assessment of Compliance through Site-Specific Visits: January 1, 2017 – December 31, 2017

Beginning in January of 2017, Medicaid staff will visit a stratified random statistically valid sample of HCBS settings to complete an on-site assessment for HCBS compliance. Settings to receive a site assessment will be selected using the following process:

- The population for each provider type will be stratified among the three geodensity areas of Frontier, Rural, and Urban counties (Frontier < 7 person per sq. miles, Rural >= 7 person per sq. miles and does not have a population center of 20,000 or greater, Urban are those counties that have a least one population center of 20,000 or greater).
- The sample size of each strata will be based on the population size of each provider type and geodensity category selected with a 95% confidence level and a ± 10% confidence Interval/ margin of error.
- A data analyst from Medicaid will use the probability sampling type of stratified random sample for the population of providers. Random numbers will be generated and assigned by the auto-process of MS Excel's "Random Number Generator" tool from the "Data Analysis" feature.
- The sample for each strata will be selected by the ascending sort order of the random numbers. The providers not selected in each strata will be placed on a replacement list and will be selected as needed based on the ascending sort order of the random numbers.

The HCBS Coordinator will be responsible for overseeing the site-specific assessment process and for tracking the outcomes. Site–specific assessments will begin January 2, 2017 and will run through December 31, 2017. A site-specific assessment tool has been developed for use during the site visits/assessments.

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

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

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

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

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

The HCBS Coordinator will report the status of the on-site assessments to the Oversight Committee and to CMS on a quarterly basis.

Following the completion of all provider site-assessments in December of 2017, a comprehensive report will be made and included in the State Transition Plan that addresses the results of all provider site-assessments. An outline of the number of site-assessments that are expected to be completed on a quarterly basis is detailed in the table located at: http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=48.

3b. Site Specific Remediation

To ensure provider compliance with HCBS rules, the state has provided extensive provider trainings that began in 2014 and continued through the end of 2016. The state is developing a toolkit that providers can utilize to comply with the HCBS rules. Below is a description of Idaho's proposed provider remediation process that will be used to track and report on progress towards full compliance.

Any HCBS provider, residential or non-residential, found to be out of compliance with the HCBS setting requirements via the initial assessment or via ongoing monitoring activities will undergo the following proposed provider remediation process.

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

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

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

3c. Participant Relocation

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

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

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

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

3d. Ongoing Monitoring

Ongoing quality assurance activities will begin January 1, 2017. Those activities include:
- Existing participant feedback mechanisms will be modified to include targeted questions about HCBS compliance in the participant's service setting. Medicaid uses the Adult Service Outcome Review (ASOR) to assess services provided to Adult Developmental Disabilities waiver participants.
- Existing Provider Quality Review processes will be modified to include components specific to HCBS compliance.
- Existing complaint and critical incident tracking and resolution processes will be modified to include an HCBS setting quality category.
- Licensing and Certification staff will be assessing compliance with some of the HCBS requirements when completing their routine surveys of Certified Family Homes and Developmental Disability Agencies. They will continue to cite on requirements that are included in their rules, and will notify the respective Bureau's Quality Assurance Specialist if issues with other HCBS requirements are identified. The Bureau's Quality Assurance Specialist will investigate and document the compliance issue in the same manner as a complaint.

Ongoing issues or trends will be reported to the Oversight Committee through March, 2019. Once Idaho has reached full compliance, issues or trends related to HCBS compliance will become part of existing quality monitoring management mechanisms. At that time the role of the Oversight Committee will be reassessed.

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

Section 4: Major Milestones for Outstanding Work

In the initial versions of the Idaho State Transition Plan Idaho included tasks for reaching compliance along with a task description and timeline. In version 4 of the STP those tasks have been moved to Attachment 5, Task Details. Only major milestones remain in the body of the STP. The tasks will continue to be updated in the attachment, but readers can find the major milestones for outstanding work and the associated timelines here. Quarterly updates on the status of incomplete work will be provided to CMS based on these milestones. The tables containing the remaining major milestones can be found at:
http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=53

Major steps and timeline for moving to full compliance include:
1. Systemic Remediation: Completed by July 2017;
2. Analysis of Settings for Characteristics of an Institution: Completed by December 2017;
3. Site-Specific Assessment: Beginning January 2017, and completed by December 31, 2017;
4. Site-Specific Remediation and Participant Relocation: Beginning as early as January 2017, and completed by March 2019; and
5. Statewide Transition Plan Revisions: Completed by July 2018

Section5: Public Input Process

The public input process, including a summary of comments received during the state's prior public comment periods and responses to those public comments can be found at:
http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=57

Attachments

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

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

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

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

Attachment 5: Task Details (located at: http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/TransitionPlanV4.pdf#page=155)

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

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

[Sections Omitted]

Appendix I: Financial Accountability

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

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

Character Count: 7204 out of 12000

The Department provides public notice of significant reimbursement changes in accordance with 42 CFR § 447.205 (made applicable to waivers through 42 CFR § 441.304(e)). The Department publishes public notice of proposed reimbursement changes in multiple newspapers throughout the State and on the Department's website at www.healthandwelfare.idaho.gov. Copies of public notices and text of proposed significant reimbursement changes are made available for public review on Department's website and during regular business hours at agency locations in each Idaho county as identified in each public notice. ~~any regional or field office of the Idaho Department of Health and Welfare and any regional or local public health district office. In Adams, Boise and Camas counties, copies of the amendments will be available at the county clerk's office in each of these counties~~. Additionally, payment rates are published on our website at www.healthandwelfare.idaho.gov for the public to access.

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

Waiver service providers will be paid on a fee for service basis as established by the Department depending on the type of service provided. The Bureau of Financial Operations is responsible for rate determinations. ~~As described below, most waiver service reimbursement rates were developed based on Personal Care Service rates and then increased or decreased based on the qualifications, supervision, and agency costs required to deliver the waiver service. This is in the methodology currently in effect.~~

Please see below for services and Reimbursement Methodology information:

Adult Day Health:

The rate was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service adjusted for employment related expenditures and indirect general and administrative costs which includes program related costs and are based on surveyed data. The rate for this service is set at a percentage of the statewide target reimbursement rate.

Behavioral Consultation/Crisis Management:

The rate was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service adjusted for employment related expenditures and indirect general and administrative costs which includes program related costs and are based on surveyed data. The rate for this service is set at a percentage of the statewide target reimbursement rate.

Chore Services:
These items are manually priced based on the submitted invoice price which cannot exceed $8.00 an hour.

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

Home Delivered Meals:
The rate is set based on Personal Care Service rates and then increased or decreased based on the qualifications to provide the waiver service, what sort of supervision was required, and agency costs associated with delivering the services.

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

Personal Emergency Response System:
The rate is developed by surveying Personal Emergency Response System vendors in all seven regions of the State to calculate a state-wide average. The state-wide average is the rate paid for this service.

Residential Habilitation:
~~The rate was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service adjusted for employment related expenditures and indirect general and administrative costs which includes program related costs and are based on surveyed data. The rate for this service is set at a percentage of the statewide target reimbursement rate.~~

The Department will survey current residential habilitation providers to identify the actual cost of providing residential habilitation services (Cost Survey). Reimbursement rates will be based on surveyed data and derived using a combination of four cost components – direct care staff wages, employer related expenditures, program related costs, and indirect general and administrative costs.

The individual components of the rate will be determined as follows: (1) the direct care staff wage component will be determined using either the wage for a comparable Bureau of Labor Statistics (BLS) occupation title, or the weighted average hourly rate from surveyed data if there is no comparable BLS occupation title; (2) the employer related expenditure component will be determined by multiplying the direct care staff wage by the cumulative percentage of employer costs for employee compensation identified by BLS for the West Region, Mountain Division and the internal revenue service employer cost for social security benefit and Medicare benefit; (3) the program related cost component will be determined by identifying the 75th percentile of the ranked program related costs from the surveyed data; and (4) the indirect general and administrative cost component will be determined by identifying the 75th percentile of the ranked general and administrative costs from the surveyed data.

Respite:
The rate is set based on Personal Care Service rates and then increased or decreased based on the qualifications to provide the waiver service, what sort of supervision was required, and agency costs associated with delivering the services.

Skilled Nursing:
These services are paid on a uniform reimbursement rate based on an annual survey conducted by the Department.

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

Supported Employment:
The rate was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service adjusted for employment related expenditures and indirect general and administrative costs which includes program related costs and are based on surveyed data. The rate for this service is set at a percentage of the statewide target reimbursement rate.

Self-Directed Services (Support Broker Services and Community Support Services):
Rates are set by the participant based on the specific needs of the participant through negotiation with the worker. The identified rates may not exceed prevailing market rates. The Department provides training and resource materials to assist the participant, support broker, and circle of supports to make this determination. The participant and the support broker monitor this requirement each time the participant enters into an employment agreement. The Department ensures that the proposed plan of service does not exceed the overall budget at the time of plan review and approval. The Department also reviews a statistically valid sample of participant employment agreements during the annual retrospective quality assurance reviews.

Financial Management Services:
Reimbursement methodology for FMS is based on a market study of other state Medicaid program rates for FMS to gather a range which allows the Department to accept a Per Member Per Month (PMPM) rate within the range determined from the market study. The established PMPM payment rates for each Department approved qualified FMS provider will be published on a fee schedule by the Department. This fee schedule will be updated at least yearly, and when new providers are approved. This information will be published for consumer convenience to the IDHW Medicaid website, and by request.

[Sections Omitted]

PRO

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	**Factor D**	**Factor D'**	**Total: D+D'**	**Factor G**	**Factor G'**	**Total: G+G'**	**Difference (Col 7 less Column4)**
1	~~48852.49~~ 49533.10	12476.88	~~61329.37~~ 62009.98	88244.20	10297.84	98542.04	~~37212.67~~ 36532.06
2	~~51289.62~~ 51938.73	13100.73	~~64390.35~~ 65039.46	88872.31	10812.73	99685.04	~~35294.69~~ 34645.58
3	~~53857.59~~ 54476.61	13755.76	~~67613.35~~ 68232.37	89500.42	11353.36	100853.78	~~33240.43~~ 32621.41
4	~~56553.81~~ 57140.11	14443.55	~~70997.36~~ 71583.66	90128.53	11921.03	102049.56	~~31052.20~~ 30465.90
5	~~59381.50~~ 59936.42	15165.73	~~74547.23~~ 75102.15	90756.65	12517.08	103273.73	~~28726.50~~ 28171.58

[Sections Omitted]

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

a. Estimate of Factor D.

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

Waiver Year: Year 1

Waiver Service / Component	Unit	# Users	Average Units Per User	Average Cost / Unit	Component Cost	Total Cost
Residential Habilitation Total:						~~**165263155.20**~~ **168730214.40**
Residential Habilitation	15 minute	3456	33440	~~1.43~~1.46	~~**165263155.20**~~ **168730214.40**	
Respite Total:						**27316.52**
Respite	15 minute	11	1267	1.96	**27316.52**	
Supported Employment Total:						**4140423.00**
Supported Employment	15 minute	684	1153	5.25	**4140423.00**	
Community Support Services Total:						**70791431.36**
Community Support Services	Per week	1334	52	1020.52	**70791431.36**	

PROPOSED DRAFT

Financial Management Services Total:						**1761840.48**
Financial Management Services	Per member per month	1334	12	110.06	**1761840.48**	
Support Broker Services Total:						**1171882.08**
Support Broker Services	15 minute	1182	216	4.59	**1171882.08**	
Adult Day Health Total:						**4487296.50**
Adult Day Health	15 minute	1767	1693	1.50	**4487296.50**	
Behavior Consultation / Crisis Management Total:						**98952.00**
Behavior Consultation / Crisis Management	15 minute	20	532	9.30	**98952.00**	
Chore Services Total:						**2488.56**
Chore Services	Per chore	6	1	414.76	**2488.56**	
Environmental Accessibility Adaptations Total:						**47282.40**
Environmental Accessibility Adaptations	Per adaptation	6	1	7880.40	**47282.40**	
Home Delivered Meals Total:						**139327.20**
Home Delivered Meals	Meal	74	360	5.23	**139327.20**	
Non-Medical Transportation Total:						**161757.64**
Non-Medical Transportation	Mile	209	1759	0.44	**161757.64**	
Personal Emergency Response System Total:						**2409.00**
Personal Emergency Response System	Month	6	10	40.15	**2409.00**	
Skilled Nursing Total:						**651986.58**
Skilled Nursing	15 minute	413	249	6.34	**651986.58**	
Specialized Medical Equipment and Supplies Total:						**107015.82**
Specialized Medical Equipment and Supplies	Piece of Equipment	43	3	829.58	**107015.82**	
				GRAND TOTAL:		**~~248854564.34~~252321623.54**
				Total Estimated Unduplicated Participants:		**5094**
				Factor D (Divide total by number of participants):		**~~48852.49~~49533.10**
				Average Length of Stay on the Waiver:		345

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 2

Waiver Service / Component	Unit	# Users	Average Units Per User	Average Cost / Unit	Component Cost	Total Cost
Residential Habilitation Total:						~~181881355.50~~ 185518982.61
Residential Habilitation	15 minute	3627	33431	~~1.50~~1.53	~~181881355.50~~ 185518/982.61	
Respite Total:						**31624.32**
Respite	15 minute	12	1267	2.08	**31624.32**	
Supported Employment Total:						**5386867.20**
Supported Employment	15 minute	858	1152	5.45	**5386867.20**	
Community Support Services Total:						**89883855.36**
Community Support Services	Per week	1608	52	1074.96	**89883855.36**	
Financial Management Services Total:						**2207462.40**
Financial Management Services	Per member per month	1608	12	114.40	**2207462.40**	
Support Broker Services Total:						**1469188.80**
Support Broker Services	15 minute	1420	216	4.79	**1469188.80**	
Adult Day Health Total:						**5138748.72**
Adult Day Health	15 minute	1811	1689	1.68	**5138748.72**	
Behavior Consultation / Crisis Management Total:						**100533.30**
Behavior Consultation / Crisis Management	15 minute	21	490	9.77	**100533.30**	
Chore Services Total:						**2613.00**
Chore Services	Per chore	6	1	435.50	**2613.00**	
Environmental Accessibility Adaptations Total:						**55162.80**
Environmental Accessibility Adaptations	Per adaptation	7	1	7880.40	**55162.80**	
Home Delivered Meals Total:						**160088.40**
Home Delivered Meals	Meal	81	360	5.49	**160088.40**	
Non-Medical Transportation Total:						**172491.88**
Non-Medical Transportation	Mile	209	1756	0.47	**172491.88**	
Personal Emergency Response System Total:						**2951.20**
Personal Emergency Response System	Month	7	10	42.16	**2951.20**	
Skilled Nursing Total:						**810940.90**
Skilled Nursing	15 minute	482	253	6.65	**810940.90**	
Specialized Medical Equipment and Supplies Total:						**123134.40**
Specialized Medical Equipment and Supplies	Piece of Equipment	48	3	855.10	**123134.40**	
				GRAND TOTAL:		~~287427018.18~~291064645.29
				Total Estimated Unduplicated Participants:		**5604**
				Factor D (Divide total by number of participants):		~~51289.62~~51938.73
				Average Length of Stay on the Waiver:		345

d. Estimate of Factor D.

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

Waiver Year: Year 3

Waiver Service / Component	Unit	# Users	Average Units Per User	Average Cost / Unit	Component Cost	Total Cost
Residential Habilitation Total:						~~**199683181.80**~~ **203498784.00**
Residential Habilitation	15 minute	3804	33435	~~1.57~~1.60	~~**199683181.80**~~ **203498784.00**	
Respite Total:						**36501.92**
Respite	15 minute	13	1288	2.18	**36501.92**	
Supported Employment Total:						**6917538.80**
Supported Employment	15 minute	1060	1153	5.66	**6917538.80**	
Community Support Services Total:						**113194575.52**
Community Support Services	Per week	1922	52	1132.58	**113194575.52**	
Financial Management Services Total:						**2748767.52**
Financial Management Services	Per member per month	1922	12	119.18	**2748767.52**	
Support Broker Services Total:						**1827360.00**
Support Broker Services	15 minute	1692	216	5.00	**1827360.00**	
Adult Day Health Total:						**5885934.08**
Adult Day Health	15 minute	1846	1696	1.88	**5885934.08**	
Behavior Consultation / Crisis Management Total:						**99607.25**
Behavior Consultation / Crisis Management	15 minute	23	425	10.19	**99607.25**	
Chore Services Total:						**3200.96**
Chore Services	Per chore	7	1	457.28	**3200.96**	
Environmental Accessibility Adaptations Total:						**64400.00**
Environmental Accessibility Adaptations	Per adaptation	8	1	8050.00	**64400.00**	
Home Delivered Meals Total:						**186088.32**
Home Delivered Meals	Meal	89	363	5.76	**186088.32**	
Non-Medical Transportation Total:						**182979.50**
Non-Medical Transportation	Mile	209	1751	0.50	**182979.50**	
Personal Emergency Response System Total:						**3187.44**

Personal Emergency Response System	Month	8	9	44.27	**3187.44**	
Skilled Nursing Total:						**1002439.68**
Skilled Nursing	15 minute	561	256	6.98	**1002439.68**	
Specialized Medical Equipment and Supplies Total:						**142443.60**
Specialized Medical Equipment and Supplies	Piece of Equipment	52	3	913.10	**142443.60**	
GRAND TOTAL:				**~~331978206.39~~335793808.59**		
Total Estimated Unduplicated Participants:				**6164**		
Factor D (Divide total by number of participants):				**~~53857.59~~54476.61**		
Average Length of Stay on the Waiver:				345		

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 4

Waiver Service / Component	Unit	# Users	Average Units Per User	Average Cost / Unit	Component Cost	Total Cost
Residential Habilitation Total:						**~~218629793.25~~ 222604880.40**
Residential Habilitation	15 minute	3963	33435	~~1.65~~1.68	**~~218629793.25~~ 222604880.40**	
Respite Total:						**42210.28**
Respite	15 minute	14	1294	2.33	**42210.28**	
Supported Employment Total:						**8794215.50**
Supported Employment	15 minute	1295	1151	5.90	**8794215.50**	
Community Support Services Total:						**141572643.68**
Community Support Services	Per week	2284	52	1192.01	**141572643.68**	
Financial Management Services Total:						**3404895.84**
Financial Management Services	Per member per month	2284	12	124.23	**3404895.84**	
Support Broker Services Total:						**2265008.40**
Support Broker Services	15 minute	2005	216	5.23	**2265008.40**	
Adult Day Health Total:						**6742008.00**
Adult Day Health	15 minute	1872	1715	2.10	**6742008.00**	
Behavior Consultation / Crisis Management Total:						**96032.50**

PROPOSED DRAFT

Behavior Consultation / Crisis Management	15 minute	25	359	10.70	**96032.50**	
Chore Services Total:						**3841.12**
Chore Services	Per chore	8	1	480.14	**3841.12**	
Environmental Accessibility Adaptations Total:						**73800.00**
Environmental Accessibility Adaptations	Per adaptation	9	1	8200.00	**73800.00**	
Home Delivered Meals Total:						**214629.80**
Home Delivered Meals	Meal	98	362	6.05	**214629.80**	
Non-Medical Transportation Total:						**193958.27**
Non-Medical Transportation	Mile	209	1751	0.53	**193958.27**	
Personal Emergency Response System Total:						**3764.88**
Personal Emergency Response System	Month	9	9	46.48	**3764.88**	
Skilled Nursing Total:						**1232811.72**
Skilled Nursing	15 minute	651	258	7.34	**1232811.72**	
Specialized Medical Equipment and Supplies Total:						**165216.48**
Specialized Medical Equipment and Supplies	Piece of Equipment	58	3	949.52	**165216.48**	
GRAND TOTAL:						**~~383434829.72~~387409916.87**
Total Estimated Unduplicated Participants:						**6780**
Factor D (Divide total by number of participants):						**~~56553.81~~57140.11**
Average Length of Stay on the Waiver:						345

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 5

Waiver Service / Component	**Unit**	**# Users**	**Average Units Per User**	**Average Cost / Unit**	**Component Cost**	**Total Cost**
Residential Habilitation Total:						**~~238659086.17~~ 242797683.04**
Residential Habilitation	15 minute	4127	33427	~~1.73~~1.76	**~~238659086.17~~ 242797683.04**	
Respite Total:						**48562.50**
Respite	15 minute	15	1295	2.50	**48562.50**	
Supported Employment Total:						**11086460.00**

PROPOSED DRAFT

Supported Employment	15 minute	1565	1150	6.16	**11086460.00**	
Community Support Services Total:						**176025865.08**
Community Support Services	Per week	2699	52	1254.21	**176025865.08**	
Financial Management Services Total:						**4199104.20**
Financial Management Services	Per member per month	2699	12	129.65	**4199104.20**	
Support Broker Services Total:						**2793113.28**
Support Broker Services	15 minute	2364	216	5.47	**2793113.28**	
Adult Day Health Total:						**7720598.40**
Adult Day Health	15 minute	1902	1720	2.36	**7720598.40**	
Behavior Consultation / Crisis Management Total:						**89376.00**
Behavior Consultation / Crisis Management	15 minute	28	285	11.20	**89376.00**	
Chore Services Total:						**4537.35**
Chore Services	Per chore	9	1	504.15	**4537.35**	
Environmental Accessibility Adaptations Total:						**84100.00**
Environmental Accessibility Adaptations	Per adaptation	10	1	8410.00	**84100.00**	
Home Delivered Meals Total:						**248259.60**
Home Delivered Meals	Meal	108	362	6.35	**248259.60**	
Non-Medical Transportation Total:						**199053.68**
Non-Medical Transportation	Mile	203	1751	0.56	**199053.68**	
Personal Emergency Response System Total:						**4392.00**
Personal Emergency Response System	Month	10	9	48.80	**4392.00**	
Skilled Nursing Total:						**1515269.43**
Skilled Nursing	15 minute	753	261	7.71	**1515269.43**	
Specialized Medical Equipment and Supplies Total:						**189449.82**
Specialized Medical Equipment and Supplies	Piece of Equipment	63	3	1002.38	**189449.82**	
GRAND TOTAL:						**~~442867227.51~~447005830.49**
Total Estimated Unduplicated Participants:						**7458**
Factor D (Divide total by number of participants):						**~~59381.50~~59936.42**
Average Length of Stay on the Waiver:						345