

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.
Provided: / / No limitations / X / With limitations*
- 2.a. Outpatient hospital services.
Provided: / / No limitations / X / With limitations*
- b. Rural health clinic services and other ambulatory services furnished
 by a rural health clinic, which are otherwise included in the State Plan.
 / X / Provided: / / No limitations / X / With limitations*
 / / Not provided.
- c. Federally qualified health center (FQHC) services and other ambulatory services that are
 covered under the plan and furnished by an FQHC in accordance with section 4231 of the State
 Medicaid Manual (HCFA-Pub. 45-4).
 / X / Provided: / / No limitations / X / With limitations*
3. Other laboratory and x—ray services.
Provided: / / No limitations / X / With limitations*

*Description provided on attachment.

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
 Provided: / / No limitations / X / With limitations*
- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*
- 4.c. Family planning services and supplies for individuals of child—bearing age.
 Provided: / / No limitations / X / With limitations*
- 4.d. Tobacco Cessation Counseling Services for Pregnant Women.
 Provided: / / No limitations / X / With limitations*
- 5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.
 Provided: / / No limitations / X / With limitations*
- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).
 Provided: / / No limitations / X / With limitations*
- 6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
 - a. Podiatrists' services.
 Provided: / / No limitations / / With limitations*
 / X / Not Provided

* Description provided on attachment.

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

// Provided: / / No limitations // With limitations*
/X/ Not provided.

c. Chiropractors' services.

// Provided: // No limitations // With limitations*
/X/ Not provided.

d. Other practitioners' services.

/X/ Provided:
// Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: // No limitations /X/ With limitations*
// Not Provided

b. Home health aide services provided by a home health agency.

Provided: // No limitations /X/ With limitations*
// Not Provided

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: // No limitations /X/With limitations*
// Not Provided

*Description provided on attachment.

Revision: HCFA-PM-91--4 (BPD)

ATTACHMENT 3.1-A

AUGUST 1991

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OMB No.: 0938-

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

// Provided: // No limitations // With limitations*

/X/ Not provided.

- 8. Private duty nursing services.

// Provided: // No limitations // With limitations*

/X/ Not provided.

*Description provided on attachment.

TN No: 06-20

Approval Date:

DEC 26 2006

Supersedes TN No. 91-20

Effective Date: 7/1/06

HCFA ID: 7986E

- 9. Clinic services.
 - // Provided: / / No limitations // With limitations*
 - / X / Not provided.
- 10. Dental services.
 - // Provided: / / No limitations // With limitations*
 - / X / Not provided.
- 11. Physical therapy and related services.
 - a. Physical therapy.
 - // Provided: / / No limitations // With limitations
 - / X / Not provided.
 - b. Occupational therapy.
 - / / Provided: / / No limitations / / With limitations*
 - / X / Not provided.
 - c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).
 - // Provided: / / No limitations // With limitations*
 - / X / Not provided.

*Description provided on attachment.

**IDAHO MEDICAID
STANDARD STATE PLAN**

Revision: HCFA—PM—85—3 (BERC)

Attachment 3.1-A

May 1985

OMB No: 0938-0193

State: IDAHO

Attachment 3.1-A - AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
- a. Prescribed drugs.
/ / Provided: / / No limitations / / With limitations*
/X/ Not provided.
 - b. Dentures.
/ / Provided: / / No limitations / / With limitations*
/X/ Not provided.
 - c. Prosthetic devices.
/ / Provided: / / No limitations / / With limitations*
/X/ Not provided.
 - d. Eyeglasses.
/ / Provided: / / No limitations / / With limitations*
/X/ Not provided.
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.
- a. Diagnostic services.
/ / Provided: / / No limitations / / With limitations*
/X/ Not provided.

**IDAHO MEDICAID
STANDARD STATE PLAN**

**Attachment 3.1-A - AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

12.a Prescribed Drugs for Tobacco Cessation.

The Department will cover tobacco cessation drug products for pregnant women when prescribed by their physician.

The following products are covered:

- Chantix tablets
- Nicotine gum, all strengths
- Nicotine lozenges, all strengths
- Nicotine patches, all strengths
- Nicotine Nasal Spray, all strengths

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

// Provided: // No limitations // With limitations*
/ X / Not provided.

c. Preventive services.

// Provided: // No limitations // With limitations*
/ X / Not provided.

d. Rehabilitative services.

// Provided: // No limitations // With limitations*
/ X / Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

// Provided: // No limitations // With limitations*
/ X / Not provided.

b. Skilled nursing facility services.

// Provided: // No limitations // With limitations*
/ X / Not provided.

c. Intermediate care facility services.

// Provided: // No limitations // With limitations*
/ X / Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

// Provided: // No limitations // With limitations*

/X/ Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

// Provided: // No limitations // With limitations*

/X/ Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

/ Provided: // No limitations / With limitations*

/X/ Not provided.

17. Nurse—midwife services.

/X/ Provided: // No limitations /X/ With limitations*

// Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

// Provided: // No limitations // With limitations*

/X/ Not provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1—A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

// Provided: // With limitations

/ X / Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

/ / Provided: / / With limitations*

/ X / Not provided.

20. Extended services for pregnant women

a. Pregnancy—related and postpartum services for a 60—day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

// Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

// Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).
/ X / Provided: / / No limitations / X / With limitations*
/ / Not provided.
22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).
/ / Provided: / / No limitations / / With limitations*
/ X / Not provided.
23. Certified pediatric or family nurse practitioners' services.
Provided: / / No limitations / X / With limitations*

*Description provided on attachment.

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- a. Transportation.
/ X/ Provided: / / No limitations / X/ With limitations*
// Not provided.
 - b. Services of Christian Science nurses.
/ / Provided: / / No limitations / / With limitations*
/ X/ Not provided.
 - c. Care and services provided in Christian Science sanitarium.
/ / Provided: / / No limitations / / With limitations*
/ X/ Not provided.
 - d. Nursing facility services for patients under 21 years of age.
// Provided: / / No limitations // With limitations*
/ X/ Not provided.
 - e. Emergency hospital services.
/ X/ Provided: / / No limitations / X/ With limitations*
/ / Not provided.
 - f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
// Provided: / / No limitations // With limitations*
/ X/ Not provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: Idaho

SECTION 3 – SERVICES: GENERAL PROVISIONS

3.1 **Amount, Duration, and Scope of Services**

Medicaid is provided in accordance with the requirements of sections 1902(a), 1902(e), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929, and 1933 of the Act; section 245A(h) of the Immigration and Nationality Act; and 42 CFR Parts 431, 440, 441, 442, and 483.

A. **Categorically Needy**

28. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary in accordance with section 1905(a)(28) of the Social Security Act and 42 CFR 440.170.

a. Transportation (provided in accordance with 42 CFR 440.170) as an optional medical service) excluding “school-based” transportation.

Not Provided:

Provided without a broker as an optional medical service:

(If state attests “Provided without a broker as an optional medical service” then insert supplemental information.)

Describe below how the transportation program operates including types of transportation and transportation related services provided and any limitations. Describe emergency and non-emergency transportation services separately. Include any interagency or cooperative agreements with other Agencies or programs.

X Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4).

(If the State attests that non-emergency transportation is being provided through a brokerage program then insert information about the brokerage program.)

Medicaid has contracted with American Medical Response (AMR) to provide non-emergent transportation services. Medicaid pays AMR a per participant per month (PPPM) amount for each eligible Medicaid participant to cover their non-emergency transportation needs. These services are provided under a brokerage model which requires AMR to coordinate all services statewide.

Medicaid’s brokerage arrangement shifts trip scheduling from being driven primarily by transportation providers to a process that is driven by the Medicaid participant’s needs. The brokerage arrangement allows for greater efficiency in assigning trips and allocating transportation resources:

The shift to a brokerage is expected to save Idaho Medicaid a minimum of \$500,000 annually as compared to past yearly expenses for this service. \$100,000 of that amount comes from state general funds at current federal matching levels.

X The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(i).

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

(1) state-wideness (indicate areas of State that are covered)

(10)(B) comparability (indicate participating beneficiary groups)

X (23) freedom of choice (indicate mandatory population groups) for all groups

(2) Transportation services provided will include:

X wheelchair van

X taxi

X stretcher car

X bus passes

X tickets

X secured transportation

X other transportation (if checked describe below other transportation.)

Passenger vehicle

(3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs:

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed qualified, competent and courteous:

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services:

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.)

- (4) The broker contract will provide transportation to the following categorically needy mandatory populations:

- X Low-income families with children (section 1931)
- X Deemed AFDC-related eligibles
- X Poverty-level related pregnant women
- X Poverty-level infants
- X Poverty-level children 1 through 5
- X Poverty-level children 6 – 18
- X Qualified pregnant women AFDC – related
- X Qualified children AFDC – related
- X IV-E foster care and adoption assistance children
- X TMA recipients (due to employment) (section 1925)
- X TMA recipients (due to child support)
- X SSI recipients

- (5) The broker contract will provide transportation to the following categorically needy optional populations:

- X Optional poverty-level - related pregnant women
 - X Optional poverty-level - related infants
 - X Optional targeted low income children
 - Non IV-E children who are under State adoption assistance agreements
 - Non IV-E independent foster care adolescents who were in foster care on their 18th birthday
 - X Individuals who meet income and resource requirements of AFDC or SSI
 - Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
 - Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
 - Children aged 15-20 who meet AFDC income and resource requirements
 - Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
 - Individuals infected with TB
 - X Individuals screened for breast or cervical cancer by CDC program
 - Individuals receiving COBRA continuation benefits
 - Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income
- standard
- X Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution

- X Individuals terminally ill if in a medical institution and will receive hospice Care
- X Individuals aged or disabled with income not above 100% FPL
- Individuals receiving only an optional State supplement in a 209(b) State
- X Individuals working disabled who buy into Medicaid (BBA working disabled group)
- Employed medically improved individuals who buy into Medicaid under TWWIA Medical Improvement Group
- X Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids).

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:

- X (i) risk capitation
- (ii) non-risk capitation
- (iii) other (e.g., brokerage fee and direct payment to providers) (If checked describe any other payment methodology)

(B) Who will pay the transportation provider?

- X (i) Broker
- (ii) State
- (iii) Other (if checked describe who will pay the transportation provider)

(C) What is the source of the non-Federal share of the transportation payments?

Describe below the source of the non-Federal share of the transportation payments proposed under the State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payment, please separately identify each source of non-Federal share funding. State funds.

X (D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

- (E) The State assures that payments proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

X (7) The broker is a non-governmental entity:

- X The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial

relationship as described at 42 CFR 440.170(4)(ii).

- The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:
 - Transportation is provided in a rural area as defined at 42 CFR 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.
 - Transportation is so specialized that there is no other available Medicaid participating provider Or other provider determined by the State to be qualified except the non-governmental broker.
 - The availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.
- (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with Another governmental entity for transportation. The governmental broker will:
- Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.
 - Document that with respect to each individual beneficiary's specific transportation needs, the government provider is the most appropriate and lowest cost alternative.
 - Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public para-transit services than the rate charged to other State human services agencies for the same service.

(9) Please describe below how the NEMT brokerage program operates. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

AMR operates a call center which receives requests from participants for transportation. AMR verifies participant eligibility and need for transportation services. AMR then schedules trips within its contracted transportation provider network.

AMR is prohibited from providing direct transportation services and does not compete with these providers.

AMR monitors the quality of service delivered by these providers and the safety of their vehicles.

AMR is paid a per member per month (PPPM) amount for each eligible participant to cover their claims administration costs, call center, payment to the transportation providers, and other operations required in the contract.

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MARCH 1987

ATTACHMENT 3.1-A

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
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g. Primary Care Case Management

/ / Not provided

/ X / Provided

State: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Su 2 to Attachment 3.1-A, and Appendices A—G to Supplement 2 to Attachment 3.1—A.

// provided / X/ not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

// Provided: // State Approved (Not Physician) Service Plan Allowed

// Services Outside the Home Also Allowed

// Limitations Described on Attachment

/ X/ Not Provided.

IDAHO MEDICAID
STANDARD STATE PLAN

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

Attachment 3.1-A

Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: No limitations With limitations None licensed or approved

Please describe any limitations:

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: No limitations With limitations (please describe below)

Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

- (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).
- (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *
- (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: Idaho -

SECTION 3 – SERVICES: GENERAL PROVISIONS

3.1 Amount, Duration, and Scope of Services

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A. Categorically Needy

28. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary in accordance with section 1905(a)(28) of the Social Security Act and 42 CFR 440.170.

a. Transportation (provided in accordance with 42 CFR 440.170) as an optional medical service) excluding "school-based" transportation.

Not Provided:

Provided without a broker as an optional medical service:

(If state attests "Provided without a broker as an optional medical service" then insert supplemental information.)

Describe below how the transportation program operates including types of transportation and transportation related services provided and any limitations. Describe emergency and non-emergency transportation services separately. Include any interagency or cooperative agreements with other Agencies or programs.

X Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4).

(If the State attests that non-emergency transportation is being provided through a brokerage program then insert information about the brokerage program.)

Medicaid has contracted with American Medical Response (AMR) to provide non-emergent transportation services. Medicaid pays AMR a per participant per month (PPPM) amount for each eligible Medicaid participant to cover their non-emergency transportation needs. These services are provided under a brokerage model which requires AMR to coordinate all services statewide.

Medicaid's brokerage arrangement shifts trip scheduling from being driven primarily by transportation providers to a process that is driven by the Medicaid participant's needs. The brokerage arrangement allows for greater efficiency in assigning trips and allocating transportation resources:

The shift to a brokerage is expected to save Idaho Medicaid a minimum of \$500,000 annually as compared to past yearly expenses for this service. \$100,000 of that amount comes from state general funds at CUITent federal matching levels.

X The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(i).

(I) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

U (1) state-wideness (indicate areas of State that are covered)

U (10)(8) comparability (indicate participating beneficiary groups)

X (23) freedom of choice (indicate mandatory population groups) for all groups

(2) Transportation services provided will include:

X wheelchair van

X taxi

X stretcher car

X bus passes

X tickets

X secured transportation

XD other transportation (if checked describe below other transportation.)

Passenger vehicle

(3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs:

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed qualified, competent and courteous:

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services:

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.)

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

- X Low-income families with children (section 1931)
- X Deemed AFDC-related eligibles
- X Poverty-level related pregnant women
- X Poverty-level infants
- X Poverty-level children 1 through 5
- X Poverty-level children 6 - 18
- X Qualified pregnant women AFDC -- related
- X Qualified children AFDC - related
- X IV-E foster care and adoption assistance children
- X TMA recipients (due to employment) (section 1925)
- X TMA recipients (due to child support)
- X SSI recipients

(5) The broker contract will provide transportation to the following categorically needy optional populations:

- X Optional poverty-level - related pregnant women
- X Optional poverty-level - related infants
- X Optional targeted low income children
- O Non IV-E children who are under State adoption assistance agreements
- O Non IV-E independent foster care adolescents who were in foster care on their 18th birthday
- X Individuals who meet income and resource requirements of AFDC or SSI
- Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
- Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
- O Children aged 15-20 who meet AFDC income and resource requirements
- O Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
- Individuals infected with TB
- X Individuals screened for breast or cervical cancer by CDC program
- O Individuals receiving COBRA continuation benefits
- Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income
- X Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution

standard

- X Individuals tenninally ill if in a medical institution and will receive hospice Care
- X Individuals aged or disabled with income not above 100% FPL
- Individuals receiving only an optional State supplement in a 209(b) State
- X Individuals working disabled who buy into Medicaid (BBA working disabled group)
- O Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
- X Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids).

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:

- X (i) risk capitation
- O (ii) non-risk capitation
- O (iii) other (e.g., brokerage fee and direct payment to providers) (If checked describe any other payment methodology)

(B) Who will pay the transportation provider?

- X (i) Broker
- (ii) State
- O (iii) Other (if checked describe who will pay the transportation provider)

(C) What is the source of the non-Federal share of the transportation payments?

Describe below the source of the non-Federal share of the transportation payments proposed under the State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payment, please separately identify each source of non-Federal share funding. State funds.

X (D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

(E) The State assures that payments proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

X (7) The broker is a non-governmental entity:

- X The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial

relationship as described at 42 CFR 440.170(4)(ii).

- O The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:
 - O Transportation is provided in a rural area as defined at 42 CFR 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.
 - ii Transportation is so specialized that there is no other available Medicaid participating provider Or other provider determined by the State to be qualified except the non-governmental broker.
 - ii The availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.
- O (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with Another governmental entity for transportation. The governmental broker will:
- ij Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.
 - O Document that with respect to each individual beneficiary's specific transportation needs, the government provider is the most appropriate and lowest cost alternative.
 - ij Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public para-transit services than the rate charged to other State human services agencies for the same service.
- (9) Please describe below how the NEMT brokerage program operates. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

AMR operates a call center which receives requests from participants for transportation. AMR verifies participant eligibility and need for transportation services. AMR then schedules trips within its contracted transportation provider network.

AMR is prohibited from providing direct transportation services and does not compete with these providers.

AMR monitors the quality of service delivered by these providers and the safety of their vehicles.

AMR is paid a per member per month (PPPM) amount for each eligible participant to cover their claims administration costs, call center, payment to the transportation providers, and other operations required in the contract.

3.1-A Amount, duration and scope of medical and remedial care and services provided:

1. Inpatient Hospital Services: No limitation is placed on the number of inpatient hospital days. However, such inpatient services must be medically necessary as determined by the Department or its authorized agent. Payment is limited to semiprivate room accommodations unless private accommodations are medically necessary and ordered by the physician.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Excluded Services:

- Elective medical and surgical treatments, except family planning services, without Department approval.
- Non-medically necessary cosmetic surgery
- New procedures of unproven value and established procedures of questionable current usefulness that are excluded by Medicare program and other commercial carriers. Questionable procedures are reviewed using the criteria listed in IDAPA 16.03.09.443.
- Surgical procedures for the treatment of morbid obesity and panniculectomies unless medically necessary for a co-morbid condition.
- Acupuncture, biofeedback therapy, and laetrile therapy Procedures, counseling, and testing for the inducement of fertility
- All transplants
- Treatment of complications, consequences, or repair of any medical procedure in which the original procedure was excluded from Medicaid, unless determined to be medically necessary by the Department or its designee
- Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21)

Limitations:

- Abortion Services - the Department will only fund abortions to save the life of the mother or in cases of rape or incest as determined by the courts. Two licensed physicians must certify in writing that the mother may die if the fetus is carried to term. This certification must contain the name and address of the recipient.

2. a. Outpatient Hospital Services Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment. Refer to items 3.1-A-i and 5 for excluded services and information concerning abortion services.

Limitations:

- Emergency room services are limited to six (6) visits per calendar year. Those services, however, which are followed immediately by admission on an inpatient status, will be excluded from the above limitation.
- b. Rural Health Clinics Services provided by nurse practitioners are limited to their scope of practice as defined in Section 54-1402(d) of Idaho Code. Services provided by physician assistants are limited to their scope of practice as defined in Section 54-1803(11) of the Idaho Code.
 - c. Federally Qualified Health Centers Federally qualified health centers provided within the scope, amount, and duration of the State's medical assistance program as described under Subsection 16.03.09.830-835 of the state of Idaho's Rules Governing Medical Assistance.
3. Other Laboratory and X-ray Services: Other laboratory and x-ray services are provided upon and under the direction of a physician or other licensed practitioner.

Excluded Services:

- Laboratory and/or x-ray procedures which are associated with excluded services found in Sections 3.1-A.1 and 3.1-A.5 of this plan are excluded from payment.

4. a. Nursing Facility Care Services: must have prepayment approval before payment is made. Such authorization is initiated by the Long Term Care Unit who secures a determination of medical entitlement from the Regional Medicaid Services Unit.

b. Health Check - Early Periodic Screening, Diagnosis and Treatment (EPSDT).

Services under EPSDT are available to all Medicaid recipients up to and including the month of their twenty-first (21st) birthday.

Screening: EPSDT services include the screening, immunization, vision, hearing and dental services as recommended by the American Academy of Pediatrics periodicity schedule.

EPSDT services also include diagnosis and treatment involving medical care within the scope of the Idaho State Plan and such other necessary health care described in Section 1905(a) of the Social Security Act, and not included in the Idaho Title XIX State Plan as required to correct or ameliorate defects and physical and mental illness discovered by the screening service. The Department will set amount, duration and scope for services provided under EPSDT. Needs for services discovered during an EPSDT screening which are outside the coverage provided by the Rules Governing Medical Assistance must be shown to be medically necessary to correct or improve the physical or mental illness discovered by the screening, ordered by the physician, nurse practitioner or physician's assistant and authorized by the Department.

Limitations

- The Department will not cover services that are not medically necessary.
- Any service identified as a result of an EPSDT screen, covered under Title XIX of the Social Security Act, and currently covered under the scope of the Idaho Medicaid program will not be subject to the existing amount, scope, and duration limitations, but will be subject to prior authorization. The additional service(s) must be documented by the attending physician as to why the service is medically necessary.
- Any service identified as a result of an EPSDT screen that is not covered or beyond the scope of coverage under section 3.1-A will require review for medical necessity and must be prior authorized prior to payment. The additional service(s) must be documented by the attending physician as to why the service is medically necessary.

4. c. Family Planning Services and Supplies for Persons of Child Bearing Age

The Department will provide family planning services which include:

- Counseling and medical services prescribed by a licensed physician, qualified certified nurse practitioner, or physician's assistant. The Department will cover diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization.
- Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives, which are limited to purchase of a three-month supply at a time.
- Sterilization procedures are limited to persons who are at least twenty-one (21) years of age or older at the time of signing the informed consent form. A person over the age of 21 that is incapable of giving informed consent will be ineligible to receive Medicaid payment for the sterilization. The person must voluntarily sign the informed consent form at least thirty (30) days, but not more than 180 days, prior to the sterilization procedure. Sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are ineligible unless ordered by the court of law. Hysterectomies performed solely for sterilization are ineligible for Medicaid payment.

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4. d. Tobacco Cessation Counseling Services for Pregnant Women

1) Face-to-Face Counseling Services provided:

(i) By or under supervision of a physician

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (none are designated at this time)

2) Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women

Provided: No limitations With limitations*

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period should be explained below.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department, as required.

5. a. **Physician Services.** The Department will reimburse for treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and in accordance to the restrictions and exclusions of coverage contained in Idaho Department of Health and Welfare Rules and Regulations.

Excluded Services:

- Elective medical and surgical treatments, except family planning services are excluded from Medicaid payment without prior approval by the Department.
- New procedures of unproven value and established procedures of questionable current usefulness that are excluded by Medicare program and other commercial carriers. Questionable procedures are reviewed using the criteria listed in IDAPA 16.03.09.443.
- Non-medically necessary cosmetic surgery
- Surgical procedures for the treatment of morbid obesity and panniculectomies unless medically necessary for co-morbid conditions.
- Acupuncture services, naturopathic services, biofeedback therapy, laetrile therapy, and eye exercise therapy
- Procedures, counseling, office exams and testing for the inducement of fertility
- All transplants
- Drugs
- The treatment of complications, consequences, or repair of any medical procedure in which the original procedure was excluded from Medicaid, unless medically necessary as determined by the Department or it's designee
- Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21)

5. a. Physician Services (cont.)

Limitations:

- Payment for tonometry is limited to two (2) exams for individuals over the age of forty (40) during any twelve (12) month period (either separately or as part of a vision exam). Individuals with a diagnosis of Glaucoma are excluded from this limitation.
- Abortion Services - The Department will only fund abortions to save the life of the mother or in cases of rape or incest as determined by the courts. Two licensed physicians must certify in writing that the mother may die if the fetus is carried to term. This certification must contain the name and address of the recipient

5.

- b. Medical and Surgical Furnished by a Dentist: The Department will reimburse for treatment of medical and surgical dental conditions by a licensed dentist subject to the limitations of practice imposed by state law, and according to the restrictions and exclusions of coverage contained in Rules Governing Medical Assistance, IDAPA 16.03.09.900 through 915.

Dentist Limitations: Elective medical and surgical dental services are excluded from Medicaid payment unless prior approved by the Department. All hospitalizations for dental care must be prior approved by the Department. Non medically necessary cosmetic services are excluded from Medicaid payment. Drugs supplied to patients for self-administration other than those allowed under Rules Governing Medical Assistance, IDAPA 16.03.09.805 through 818 are excluded from Medicaid payment.

6.

- d. Services under Other Practitioners: Includes those services provided by a nurse practitioner and physician assistant as defined by state and federal law. This coverage has the same exclusions as listed in Attachment 3.1.A Program Description 5.a. Physician Services.

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(6.d continued)

Licensed Midwife (LM)

Licensed Midwife services include maternal and newborn care provided by LM providers within the scope of their practice. Medicaid will reimburse LM providers for antepartem, intrapartum, up to six (6) weeks of postpartum maternity care, and up to six weeks of newborn care.

7. Home Health Services

- a. Intermittent or part time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area when prior authorized by the Department.
- b. Home Health Aide Services Provided by a Home Health Agency when prior authorized by the Department.
- c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home:
Program Requirements: To control utilization, all medical equipment and medical supplies must be ordered in writing by a physician. Items not specifically listed in the Rules Governing Medical Assistance, IDAPA 16.03.09.751-765 will require prior authorization by the Department. Medical equipment and supplies are provided only on a written order from a physician that includes the medical necessity documentation listed in the Medicare DMERC Supplier manual.

17. Certified Nurse Midwife Services

Those services provided by certified nurse midwives as defined by state and federal law.

This coverage has the same exclusions as listed in Attachment 3.1-A Program Description 5.a Physician Services

21. Ambulatory Prenatal Care for Pregnant Women During a Presumptive Eligibility Period by an eligible provider (in accordance with section 1920 of the Act).

During the presumptive eligibility period, outpatient services related to pregnancy and complication thereof are covered. Extended services are not covered under the presumptive eligibility period.

23. Certified Pediatric or Family Nurse Practitioners' Services

Those services provided by certified pediatric or family nurse practitioners as defined by state and federal law. This coverage has the same exclusions as listed in Attachment 3.1-A Program Description 5.a. Physician Services. This coverage specifically includes services by certified pediatric and family nurse practitioners as required by Section 1905(a) (21) of the Act.

- 24. a. Transportation. Transportation services and assistance for eligible persons to covered medical services in the form of “necessary” transportation is provided. Transportation to services for the performance of medical services or procedures which are excluded from 3.1-A Program Description is excluded from transportation reimbursement. Transportation to services authorized under EPSDT is covered.

- e. Emergency Hospital Services. Emergency room services are limited to six (6) visits per calendar year. Those services, however, which are followed immediately by admission on an inpatient status, will be excluded from the above limitation.

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1915(i) STATE PLAN HOME AND COMMUNITY-BASED SERVICES

A. Children with Developmental Disabilities

**1915(i) State plan Home and Community-Based Services
Administration and Operation**

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. Services. (Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):

Respite Habilitative Supports Family Education Family-Directed Community Support Services Financial Management Services Support Broker

2. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. (Select one):

X	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program (select one):	
i	The Medical Assistance Unit (name of unit):	
X	Another division/unit within the SMA that is separate from the Medical Assistance Unit (name of division/unit)	
	This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	Division of Family and Community Services, Department of Health and Welfare
i	The State plan HCBS benefit is operated by (name of agency)	
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

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Distribution of State plan HCBS Operational and Administrative Functions.

X (By checking this box the State assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (check each that applies):

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	p	..	..	..
2 Eligibility evaluation	p	..	p	..
3 Review of participant service plans	p	..	p	..
4 Prior authorization of State plan HCBS	p	..	..	..
5 Utilization management	p	..	..	..
6 Qualified provider enrollment	p	..	..	..
7 Execution of Medicaid provider agreement	p	..	..	..
8 Establishment of a consistent rate methodology for each State plan HCBS	p	..	..	..
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	p	..	..	..
10 Quality assurance and quality improvement activities	p	..	..	..

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Eligibility evaluation: Contracted Independent Assessment Provider Review of participant service plans: Case management contractor(s)
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(By checking the following boxes the State assures that):

5. **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
- related by blood or marriage to the individual, or any paid caregiver of the individual
 - financially responsible for the individual
 - empowered to make financial or health-related decisions on behalf of the individual
 - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

N/A

6. **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
7. **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
8. **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

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Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of
Year 1	July 1,2016	June 30, 2017	203
Year 2	July 1, 2017	June 30, 2018	244
Year 3	July 1, 2018	June 30, 2019	293
Year 4	July 1, 2019	June 30, 2020	352
Year 5	July 1, 2020	June 30, 2021	422

Please Note: The original 1915(i) application used 1915(c) waiver participants in the projected number calculations in error. This corrected chart reflects the appropriate approximated numbers of participants eligible for this 1915(i) State plan option.

- 2. Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

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Financial Eligibility

1. **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State’s Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL. This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.

2. **Medically Needy.** *(Select one):*

X	The State does not provide State plan HCBS to the medically needy.
i	The State provides State plan HCBS to the medically needy <i>(select one):</i>
i	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
i	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual. Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed *(select one):*

i	Directly by the Medicaid agency
X	By Other <i>(specify State agency or entity with contract with the State Medicaid agency):</i>
	Contracted Independent Assessment provider(s) will be determined according to state purchasing requirements.

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

Per contract requirements, contractor staff must comply, at a minimum, with Qualified Intellectual Disabilities Professional (QIDP) requirements in accordance with 42 CFR 483.430a.
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- 3. Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Participants applying for 1915(i) state plan option services will be referred to the independent assessment provider (IAP) for initial eligibility determination.

The IAP conducts and/or collects a variety of assessments and determines the participant's individual budget at the time of initial application and on an annual basis, for both the traditional and the family-directed services options. The IAP will evaluate the participant through face-to-face consultation with the participant, and if applicable, the participant's decision-making authority. Functional assessment evaluations are conducted using the Scales of Independent Behavior-Revised (SIB-R) and a Department-developed inventory of individual needs to determine if the participant meets the needs-based criteria. The inventory of individual needs includes a summary of medical, social and developmental status and helps to determine categorical eligibility. This summary process includes an evaluation of existing participant documentation of medical assessments, diagnostic assessment, and psychometric testing. If there is no current testing, diagnostic testing may be completed by the IAP if necessary.

Eligibility determinations must be completed within thirty (30) days of the new referral. Reevaluations of eligibility must be completed annually and require either a full reassessment or a focused review. A full assessment is required at least every three (3) calendar years. An independent needs-based inventory must be conducted at least every twelve (12) months to assess a participant's support needs and determine the participant's eligibility for HCBS State plan services. Eligibility determination is made by using the needs-based eligibility criteria that has been established by the State.

- 4. Needs-based HCBS Eligibility Criteria.** *(By checking this box the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

An eligible participant must:

Require assistance due to substantial limitations in three (3) or more of the following major life activities - self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self sufficiency; and

Reflect the need for a combination and sequence of special, interdisciplinary services due to a delay in developing age appropriate skills occurring before the age of twenty-two (22).

- 5. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits 1915(i) state plan option services to a group or subgroups of individuals:

Children, birth through age seventeen (17), who are determined to have a developmental disability in accordance with Sections 500 through 506 under IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits" and Section 66-402, Idaho Code.

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6. **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/ID (& ICF/ID LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
<p>Require assistance due to substantial limitations in three or more of the following major life activities - self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self sufficiency; and Reflect the need for a combination and sequence of special, interdisciplinary services due to a delay in developing age appropriate skills occurring before the age of 22.</p>	<p>The participant requires nursing facility level of care when a child meets one (1) or more of the following criteria: 01. Supervision Required for Children. Where the inherent complexity of a service prescribed by the physician is such that it can be safely and effectively performed only by or under the supervision of a licensed nurse or licensed physical or occupational therapist. 02. Preventing Deterioration for Children. Skilled care is needed to prevent, to the extent possible, deterioration of the child's condition or to sustain current capacities, regardless of the restoration potential of a child, even where full recovery or medical improvement is not possible. 03. Specific Needs for Children. When the plan of care, risk factors, and aggregate of health care needs is such that the assessments, interventions, or</p>	<p>01. Diagnosis. Persons must be financially eligible for Medicaid; must have a primary diagnosis of being intellectually disabled or have a related condition defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition; and 02. Must Require Certain Level of Care. Persons living in the community must require the level of care provided in an ICF/ID, including active treatment, and in the absence of available intensive alternative services in the community, would require institutionalization, other than services in an institution for mental disease, in the near future; and 03. Functional Limitations. a. Persons Sixteen Years of Age or Older. Persons (sixteen (16) years of age or older) may qualify</p>	<p>The state uses criteria defined in 42 CFR 440.10 for inpatient hospital services.</p>

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	<p>supervision of the child necessitates the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and therapy notes.</p> <p>04. Nursing Facility Level of Care for Children. Using the above criteria, plus consideration of the developmental milestones, based on the age of the child, the Department's will determine nursing facility level of care.</p>	<p>based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on a full scale functional assessment (Woodcock Johnson Scales of Independent Behavior, or SIB-R, or subsequent revisions) would qualify; or</p> <p>b. Persons Under Sixteen Years of Age. Persons (under sixteen (16) years of age) qualify if their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or</p> <p>04. Maladaptive Behavior.</p> <p>a. A Minus Twenty-Two (-22) or Below Score. Individuals may qualify for ICF/ID level of care based on maladaptive behavior. Persons will be eligible if their General Maladaptive Index on the Woodcock Johnson Scales of Independent Behavior (SIB-R) or subsequent revision is minus twenty-two (-22) or less; or</p> <p>b. Above a Minus Twenty-Two (-22) Score. Individuals who score above minus twenty-two (-22) may qualify for ICF/ID level of care if they engage in aggressive or self injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and the person requires active treatment</p>
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		<p>to control or decrease the behavior; or</p> <p>05. Combination Functional and Maladaptive Behaviors. Persons may qualify for ICF/ID level of care if they display a combination of criteria as described in Subsections 585.05 and 585.06 of these rules at a level that is significant and it can be determined they are in need of the level of services provided in an ICF/ID, including active treatment services. Significance would be defined as: (3-19-07) a. Persons Sixteen Years of Age or Older. For persons sixteen (16) years of age or older, an overall age equivalency up to eight and one-half (8 1/2) years is significant in the area of functionality when combined with a General Maladaptive Index on the Woodcock Johnson SIB-R up to minus seventeen (-17), minus twenty-two (-22) inclusive; or b. Persons Under Sixteen Years of Age. For persons under sixteen (16) years of age, an overall age equivalency up to fifty-three percent (53%) of their chronological age is considered significant when combined with a General Maladaptive Index on the Woodcock Johnson SIB-R between minus seventeen (-17), and minus twenty-one (-21) inclusive; or</p> <p>06. Medical Condition. Individuals may meet ICF/ID level of care based</p>
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		on their medical condition if the medical condition significantly affects their functional level/capabilities and it can be determined that they are in need of the level of services provided in an ICF/ID, including active treatment services.	
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(By checking the following boxes the State assures that):

- 7. **Reevaluation Schedule.** Needs-based eligibility reevaluations are conducted at least every twelve months.
- 8. **Adjustment Authority.** Per 42 CFR 441.715(c), the State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).
- 9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.		Minimum number of services. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is:
	1	
ii.		Frequency of services. The state requires (select one):
	<input checked="" type="checkbox"/>	The provision of 1915(i) services at least monthly
	i	Monthly monitoring of the individual when services are furnished on a less than monthly basis If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

- 10. **Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:
 - (i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or
 - (ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

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Idaho assures that the setting transition plan included with this 1915(i) State Plan Amendment 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 its 1915(i) State Plan Amendment, as needed, when it submits the next amendment or renewal. The most recent version of the Statewide Transition Plan can be found here:

<http://healthandwelfare.idaho.gov/Medical/Medicaid/HomeandCommunityBasedSettingsFinalRule/tabid/2710/Default.aspx>

The intention of the home and community-based services (HCBS) rule is to ensure individuals receiving HCBS long-term services and supports 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 administers several HCBS programs that fall under the scope of the new regulations, including the 1915(i) program for children with developmental disabilities.

The Children’s 1915(i) only serves participants in non-residential settings. As part of Idaho’s Statewide Transition Plan, a preliminary gap analysis of its non-residential HCBS settings was completed in December 2014. The gap analysis included an in-depth review of state administrative rule and statute, Medicaid waiver and state plan language, licensing and certification requirements, Medicaid provider agreements, service definitions, administrative and operational processes, provider qualifications and training, quality assurance and monitoring activities, reimbursement methodologies, and person-centered planning processes and documentation. This analysis identified areas where the new regulations are supported in Idaho as well as areas that will need to be strengthened in order to align Idaho’s HCBS programs with the regulations.

Below is an exhaustive list of the HCBS administered to participants in the children’s 1915(i) program, the corresponding category for each service, and the settings in which the service can occur. 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	Applicable HCBS Qualities	Setting(s)
Respite	Non-residential	<ul style="list-style-type: none"> • Home • Community • DDA Center
Habilitative supports	Non-residential	<ul style="list-style-type: none"> • Home • Community • DDA Center
Family education	Non-residential	<ul style="list-style-type: none"> • Home • Community • DDA Center

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Supports for Family - Directed Services		
Community Support Services	Non-residential	<ul style="list-style-type: none"> • Home • Community • DDA Center
Financial Management Services	Non-residential	<ul style="list-style-type: none"> • Home
Support Broker	Non-residential	<ul style="list-style-type: none"> • Home

Systemic Assessment and Systemic Remediation: Non-Residential Settings

As part of its systemic assessment, Idaho completed a preliminary gap analysis of its non-residential service settings in December 2014. The results of Idaho’s analysis of its non-residential settings are summarized below, including an overview of existing support for each regulation. The state has included, where applicable, the full IDAPA rule citation(s) to identify where IDAPA supports the HCBS requirement, in addition to indicating if IDAPA is silent. The state did not identify any IDAPA rule that conflicts with the HCBS requirements. Additionally the chart includes preliminary recommendations to transition these settings into full compliance with the new regulations. Please note that the analysis of existing support for each new regulation is only the first step in the assessment process. It has been used to identify where Idaho lacks documented support for the setting quality requirements. Idaho understands that more work is necessary to complete a full assessment of settings.

Of the 6 services listed in the table above, only the habilitative support service was included in the systemic assessment’s non-residential service settings gap analysis. The state determined that the other services did not have gaps related to HCBS setting requirements as they 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 those services, a detailed analysis was not necessary. The gap analysis conducted for habilitative supports is provided below:

Federal Requirement	Habilitative Supports	
The setting is integrated in, and facilitates the individual’s full access to the greater community to the same degree of access as individuals not receiving Medicaid HCBS.	Support	Idaho rule (IDAPA 16.03.10.521.18, 16.03.10.683.04.b, and 16.03.10.683.04.c.ii.) allows habilitative supports to be provided in three different settings. Idaho rule supports that service settings are integrated and facilitate community access when provided in the home and community.
	Gap	The state lacks quality assurance/monitoring activities to ensure this requirement is met. The state lacks standards for integration for services provided in a congregate setting. The state lacks standards for “the same degree of access as individuals not receiving Medicaid HCBS.”
	Remediation	Enhance and expand existing quality assurance/monitoring activities and data collection for monitoring. Strengthened IDAPA 16.03.10.313 to support this requirement. Develop best practice to support

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		provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
The setting includes opportunities to seek employment and work in competitive, integrated settings to the same degree of access as individuals not receiving Medicaid HCBS.	Support	None
	Gap	IDAPA is silent
	Remediation	This service benefit is for children who would not be seeking employment due to their age
The setting includes opportunities to engage in community life to the same degree of access as individuals not receiving Medicaid HCBS.	Support	Idaho rule (IDAPA 16.03.10.521.18, 16.03.10.683.04.b, and 16.03.10.683.04.c.ii.) supports that service settings include opportunities to engage in community life when services are provided in the home and community.
	Gap	The state lacks quality assurance/monitoring activities to ensure this requirement is met. The state lacks best practices for integration for services provided in a congregate setting. The state lacks best practices for "the same degree of access as individuals not receiving Medicaid HCBS."
	Remediation	Enhance existing quality assurance/monitoring activities and data collection for monitoring. Strengthened IDAPA 16.03.10.313 to support this requirement. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
The setting includes opportunities to control personal resources to the same degree of access as individuals not receiving Medicaid HCBS.	Support	Providers have no authority to control participant resources.
	Gap	The state lacks quality assurance/monitoring activities to ensure this requirement is met. The state lacks rule support for this requirement. IDAPA is silent. The state lacks best practices for "the same degree of access as individuals not receiving Medicaid HCBS."
	Remediation	Enhance existing quality assurance/monitoring activities and data collection for monitoring. Incorporate HCBS requirement into IDAPA 16.03.10.313. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
The setting includes opportunities to receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.	Support	Idaho rule (IDAPA 16.03.10.521.18, 16.03.10.683.04.b, and 16.03.10.683.04.c.ii.) supports that service settings include opportunities to receive services in the community when services are provided in the home and community.
	Gap	The state lacks quality assurance/monitoring activities to ensure this requirement is met. The state lacks best practices for integration for services provided in a congregate setting. The state lacks best practices for "the same degree of access as individuals not receiving

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		Medicaid HCBS.”
	Remediation	Enhance existing quality assurance/monitoring activities and data collection for monitoring. Strengthened IDAPA 16.03.10.313 to support this requirement. Develop best practices to support provider compliance with this HCBS requirement. Include it in the HCBS toolkit.
The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and based on the individual’s needs, preferences, and resources available for room and board (for residential settings).	Support	Providers have no capacity to control the participant’s selection of the residential setting.
	Gap	IDAPA is silent
	Remediation	It is assumed that children are residing at home with their parents (or legal guardian) rather than in residential settings.
An individual’s essential personal rights of privacy, dignity, respect, and freedom from coercion and restraint are protected.	Support	Idaho rule (IDAPA 16.03.21.905.01, 16.03.21.905.02, 16.03.21.905.03. a-d) supports that an individual’s rights of privacy, dignity, respect, and freedom from coercion and restraint are protected (licensing and certification rules). IDAPA 16.03.21.915 describes the process used to implement authorized restraints. These rules are monitored and remediated by L&C.
	Gap	None
	Remediation	None
Optimizes, but does not regiment individual initiative, autonomy, and independence in making life choices. This includes, but is not limited to, daily activities, physical environment, and with whom to interact.	Support	Idaho rule (IDAPA 16.03.10.526.06) supports that an individual’s initiative, autonomy, and independence in making life choices is facilitated in the community.
	Gap	The state lacks quality assurance/monitoring activities to ensure this requirement is met.
	Remediation	Enhance quality assurance/monitoring activities and data collection for monitoring. Incorporated HCBS requirement into IDAPA 16.03.10.313.
Individual choice regarding services and supports, and who provides them, is facilitated.	Support	Idaho rule (IDAPA 16.03.10.526.06) supports that an individual has the choice of services. The state lacks regulation that supports choice of who provides them. This requirement is monitored through the Family and Community Services Quality Assurance assessment.
	Gap	The state lacks regulation that supports choice of who

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		provides chosen services.
	Remediation	Incorporated HCBS requirement into IDAPA 16.03.10.313.

Analysis of Non-Residential Settings for Characteristics of an Institution

In addition to the systemic assessment described above, Idaho conducted an analysis of non-residential 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. 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.

Idaho’s children’s 1915(i) HCB services by definition must occur in a participant’s private residence, the community, or in developmental disabilities agencies (DDAs). A setting in a participant’s private residence or the community is presumed to be compliant with all HCBS requirements. DDAs were examined for this non-residential service setting analysis.

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 visits 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 January, 2017, Idaho will begin a site-specific assessment and site-specific remediation process to assess and monitor HCBS settings for compliance with the HCBS setting requirements. DDAs will be included in this process.

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Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1. There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.
2. Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).
3. The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.
4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. (Specify qualifications):

At a minimum, individuals conducting the independent assessment must meet the requirements for a. Qualified Intellectual Disability Professional (QIDP) in accordance with 42 CFR 483.430. QIDP requirements include:

- a. Having at least one (1) year experience working directly with persons with intellectual disabilities or other developmental disabilities or;
- b. Being licensed as a doctor of medicine or osteopathy, or as a nurse or;
- c. Having at least a bachelor's degree in one of the following professional categories: psychology, social work, occupational therapy, speech pathology, professional recreational therapy, or other related human services professions.
- d. Have training and experience in completing and interpreting assessments.

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- 4. Responsibility for Plan of Care Development.** There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. (*Specify qualifications*):

In accordance with regulations contained in Idaho Administrative Code – IDAPA 16.03.10, Home and Community-Based Services (HCBS) rules, a paid or non-paid person who, under the direction of the participant or their decision-making authority, is responsible for developing a single plan of service and subsequent addenda. The service plan must cover all services and supports identified during the family-centered planning process and must meet the HCBS person-centered plan requirements as described in the IDAPA rules previously identified.

The responsibility for service plan development and qualifications differ slightly based on the participant's selection of either traditional services or family-directed services.

Traditional Services:

Paid plan development under the traditional services option must be provided by the Department or its contractor in accordance with the noted HCBS rules. Neither a provider of direct services to the participant nor the assessor may be chosen to develop the plan of service.

Paid plan developers are called case managers. Case Management Qualifications:

Case Manager - Minimum of a Bachelor's Degree in a human services field from a nationally accredited university or college and have 24 months supervised experience working with children with disabilities, and pass a Department criminal history background check.

Clinical Case Management Supervisor - Minimum of a Master's Degree in a human services field from a nationally accredited university or college and have 12 months supervised experience working with children with disabilities, and pass a Department criminal history background check.

Family-Directed Services:

Non-paid plan development is allowed under the family-directed services option and may be provided by the family, or a person of their choosing, in accordance with the stated HCBS rules, when this person is not a paid provider of services identified on the child's plan of service. Alternatively, the family may choose to hire a Department approved support broker to assist with plan development and purchase specific duties as needed. Plan developers under the Family-Directed Services option are called Support Brokers.

Specific qualifications for support brokers are outlined in Idaho Administrative Code - IDAPA 16.03.13. The qualification requirements include review of the individual's education and experience. Support brokers must demonstrate successful completion of the Department's Support Broker training and of the required ongoing education.

- 5. Supporting the Participant in Plan of Care Development.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. (*Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process*):

Participants who are eligible for and select State plan HCBS are given an orientation to the available developmental disability services by the Independent Assessment Provider (IAP) and their case manager or support broker.

Participants and their decision making authority that chose traditional services may develop their own plan or use a case manager from the Department. If the participant and the participant's decision making authority choose to develop their own plan or use an unpaid natural support, the Department's case manager is available to assist in completing all required components. The family-centered planning team must include people chosen by the participant the family and the participant's decision making authority, if applicable.

Participants and their decision-making authority that choose family-directed services receive an orientation on family-direction and program training from the Department. Families may select a qualified support broker to assist with writing of the Support and Spending Plan, or they may choose to become a qualified support broker approved by the Department. As outlined in IDAPA 16.03.13, "Consumer-Directed Services," the participant and the participant's decision-making authority decide who will participate in the planning sessions in order to ensure the participant's choices are honored and promoted. The family may direct the family-centered planning meetings, or

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these meetings may be facilitated by a chosen support broker. In addition, the participant and the participant's decision-making authority select a circle of support. Members of the circle of support attend the family-centered planning meetings and commit to work within the group to help promote and improve the life of the participant in accordance with the participant's choices and preferences. They also agree to meet on a regular basis to assist the participant and participant's decision-making authority to accomplish their expressed goals. In developing the plan of service, the family-centered planning team must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals.

Plan developers and support brokers are responsible for the documentation of the developed plan and any subsequent plan changes as determined by the family-centered planning team. Individuals responsible for facilitating the person-centered planning meeting and developing the plan of service cannot be providers of direct services to the participant.

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6. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

Once participants are determined eligible for services, they and their families are given an opportunity to participate in orientation training about developmental disability services in Idaho. During family orientation, participants and their families are provided with a list of all approved providers in the state of Idaho, which is organized by geographic area. The printed materials provided to families include the website link for the Idaho State children's DD website at www.redesignforchildren.medicaid.idaho.gov where electronic versions of documents are available. Both the orientation materials and the provider list include a statement that the family may choose any willing and available provider in the state. Families are also informed of how to navigate the website to access the list of providers as well as how to access other helpful resources available to them.

Families are also provided with resources on interviewing potential providers and are encouraged to contact multiple providers to identify the provider that can best meet their needs. In addition, families are informed that who they select is their choice and they may change their choice of providers if they want. Families are encouraged to access the Department case manager if needed to assist families in selecting or changing service providers. at the participant's or the participant's decision making authority's request.

7. Process for Making Plan of Care Subject to the Approval of the Medicaid Agency. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

In both the traditional and family-directed options, the plan is developed by the participant, the participant's decision-making authority and the family-centered planning team as selected by the participant and family. The plan of service must identify all services and supports that were determined through a family-centered planning process. This plan development is required in order to provide DD services to children from birth through seventeen (17) years of age. A plan of service must identify, at a minimum, the type of service to be delivered, goals and desired outcomes to be addressed within the plan year, strengths and preferences of the participant, including the participant's safety and the safety of those around the participant, target dates, and methods of collaboration. The independent assessment meets the federal requirements at 42 CFR §441.720 and is used to develop the individual plan of service. Additionally, the person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

The plan of service must be developed in accordance with the Home and Community-Based Services (HCBS) regulations as stated in IDAPA 16.03.10. The plan developer is responsible for the documentation of the developed plan and any subsequent plan changes as determined by the family-centered planning team. In the traditional services model, the plan developer submits the plan of service to the Department. The Department has 10 business days to review and authorize the plan.

When the family-directed service model is chosen, the participant and the participant's decision making authority, and their circle of supports are in charge of how long the plan development process takes. The process may take from a few days to much longer, depending on the needs and wants of the participant, their family and decision-making authority and the participant's family-centered planning team. Once the family-planning process has been completed, the support broker is responsible to submit the participant's Support and Spending Plan directly to the Department for review and authorization. The Department has ten (10) business days to review and authorize the plan.

The participant and parent/decision-making authority and their circle of supports are in charge of how long the plan development process takes. The process may take from a few days to much longer, depending on the needs and wants of the participant, their family, and the support team.

The IAP conducts and/or collects a variety of assessments and determined the participant's individual budget at the time of initial application and on an annual basis, for both the traditional and the family directed option. The IAP conducts the following assessments at the time of the initial application for children's DD services:

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- Scales of Independent Behavior- Revised (SIB-R) functional assessment
- Medical, Social and Developmental Assessment Summary

At the time of annual re-determination, the IAP conducts and/or reviews the following:

- The Medical, Social, and Developmental Assessment Summary is reviewed and updated.
- The SIB-R results are reviewed and another assessment is performed if there are significant changes in the participant's situation or the reassessment criteria are met.

All service plans must be finalized and agreed to, by the participant, or the participant's decision making authority, in writing, indicating informed consent. Plans must also be signed by all individuals and providers responsible for its implementation indicating they will deliver services according to the authorized plan of service and consistent with home and community based requirements as described in IDAPA 16.03.10.

Individual service plans are distributed to the participant and the participant's decision-making authority, if applicable, and other people involved in the family-centered planning and implementation of the plan.

Medicaid has operational processes that optimize participant independence, community integration and choices in daily living. These processes include the requirement for HCBS benefits to be requested through a participant's plan. Once plans are developed through the family-centered planning process, the plans are submitted to Medicaid for prior authorization. The prior authorization process is used to ensure the provision of services that enhance health and safety, promote participant rights, self-determination and independence according to IDAPA 16.03.10.526.

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The following assessments are gathered on an as-needed basis or may be used as historical information at the time of both initial and annual re-determinations:

- Psychological evaluations, including evaluations regarding cognitive abilities, mental health issues and issues related to traumatic brain injury.
- Neuropsychological evaluations.
- Physical, occupational and speech-language pathology evaluations.
- Developmental and specific skill assessments.

The results of a physical examination by the participant's primary care physician are provided to the case manager on an annual basis. Participants using traditional State plan HCBS, and their support team, must be assessed for health and safety issues. Participants using the family-directed option, and their support team, must complete safety plans related to any identified health and safety risks and submit them to the Department.

In the traditional option, the participant and parent/decision-making authority needs, goals, preferences and health status are summarized on the plan of service. This document is a result of the family-centered planning meeting listing a review of all assessed needs and participant and parent/legal guardian preferences. In addition, the case manager is responsible to collect data status reviews from all paid providers, synthesize all of the information and include it on the plan of service. The participant's parent/decision-making authority sign the plan of service to indicate it is correct, complete, and represents the participant and parent/decision-making authority's needs and wants.

Family-directed participant needs, goals, preferences, health status, and safety risks are summarized on the Support and Spending Plan and in the Family-Direction workbook. The circle of supports, using family-centered planning, develops these documents and submits them to the Department at the time of initial/annual plan review.

Participants and their parent/decision-making authority, along with other members of the support team can receive information regarding State plan HCBS through several methods:

- The Department of Health and Welfare web site has a page specific for Children's DD Services that includes FAQ's, provider forms, rules, services, list of available providers, and other important resources. The website is found at www.redesignforchildren.medicaid.idaho.gov.

The Department of Health and Welfare's web site also has a page specific for family-directed services found at www.familydirected.dhw.idaho.gov.

- The IAP provides each new applicant with an informational packet which includes a listing of providers in the local area that provide developmental disabilities services for children, as well as a list of the services available under the children's DD program.

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- The case manager is charged with verbally explaining the various programs and options to the participant and parent/decision-making authority during the family-centered planning process, under the traditional option.
- The support broker is charged with assisting the participant and parent/decision-making authority to assess what services meet their needs, under the family-direction option.

Idaho requires that a family-centered planning process be utilized in plan development to ensure that participant goals, needs and preferences are reflected on the plan of service or on the Support and Spending Plan.

Case managers are trained in family-centered planning, and possess the education and experience needed to assist families in making decisions about their child's course of treatment and Medicaid services. The child's goals, needs, and resources are identified through a comprehensive review process that includes review of assessments and history of services, and family-centered planning.

Parents/decision-making authorities who choose to family-direct must attend training offered by the Department prior to submitting a Support and Spending Plan. Completion of this training is documented in the family-direction quality assurance database. The training covers participant and parent/decision-making authority responsibilities in family-direction and the process of developing a Support and Spending Plan. The family-directed option utilizes a workbook and a support broker to ensure that the participant's individual goals, needs and preferences are thoroughly explored and prioritized during the plan development process.

Children's State plan HCBS participants may receive a variety of services and other supports to address their needs and wants. The family-centered planning team works to ensure that the plan of service adequately reflects the necessary services. The plan of service is a single plan that includes the goals, objectives and assessment results from all of a child's services and supports in the child's system of care. The plan of service will demonstrate collaboration is taking place among providers and that objectives are directly related to the goals of the family.

Under the traditional option, the responsibility is placed on the case manager, IAP, and Department to complete the plan development process.

- The IAP is responsible to submit the assessment and individual budget to the Department.
- The Department assigns either a contracted case manager or Department staff to deliver case management and is responsible to:
 - Ensure that services are not duplicative, and are complementary and appropriate
 - Work with the members of the family-centered planning team and providers to ensure that the service needs of the participant are reflected on the plan of service
 - Act as the primary contact for the family and providers
 - Link the family to training and education to promote the family's ability to competently choose from existing benefits
 - Complete a comprehensive review of the child's needs, interests, and goals
 - Assist the family to allocate funding from their child's individual budget
 - Monitor the progress of the plan of service
 - Ensure that changes to the plan of service are completed when needed
 - Facilitate communication between the providers in a child's system of care

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8. Maintenance of Plan of Care Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (*check each that applies*):

<input checked="" type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input checked="" type="checkbox"/>	Case manager
<input type="checkbox"/>	Other (<i>specify</i>):				

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Services

1. State plan HCBS. (Complete the following table for each service. Copy table as needed):

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):			
Service Title:	Respite		
Service Definition (Scope):			
<p>Respite provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver. Respite is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Respite may be provided in the participant's home, the private home of the respite provider, a developmental disabilities agency, or in community settings.</p> <p>Respite may only be offered to participants who have an unpaid primary caregiver living in the home who requires relief.</p> <p>Limitations:</p> <ul style="list-style-type: none"> • The amount of respite services available are based on an individual's approved support and spending plan that is subject to the individual budget maximum allowed for 1915(i) services. • Payment for respite services are not made for room and board. • Respite cannot be provided during the same time other Medicaid services are being provided to a participant. • Respite cannot be provided on a continuous, long-term basis where it is part of daily services that would enable an unpaid caregiver to work. <p>- Respite cannot be provided as group- or center-based respite when delivered by an independent respite provider.</p> <ul style="list-style-type: none"> • Respite services shall not duplicate other Medicaid reimbursed services. 			
Additional needs-based criteria for receiving the service, if applicable (specify):			
N/A			
Specify limits (if any) on the amount, duration, or scope of this service for (choose each that applies):			
<input checked="" type="checkbox"/>	Categorically needy (specify limits):		
	Subject to individual budget maximums.		
<input type="checkbox"/>	Medically needy (specify limits):		
Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Developmental Disabilities Agency		<i>Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative</i>	Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide respite in a DDA:

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		Code.	Providers must be at least 16 years of age when employed by a DDA or Infant Toddler Program; meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the participant and parent/legal guardian; have received care giving instructions in the needs of the participant who will be provided the service; demonstrate the ability to provide services according to a plan of service; pass a criminal background check and must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter .
Independent Respite Care Provider			<p>Individuals must meet the following qualifications to provide respite:</p> <p>Independent respite care providers must enroll as an Idaho Medicaid provider and meet the following:</p> <p>Providers must be at least eighteen (18) years of age and be a high school graduate, or have a GED; meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the participant and parent/legal guardian; have received care giving instructions in the needs of the participant who will be provided the service; demonstrate the ability to provide services according to a plan of service; pass a criminal background check; and must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter.</p>
Early Intervention Provider			Providers must be at least 16 years of age when employed by a DDA or Infant Toddler Program; meet the qualifications prescribed for the type of services to be rendered; have received care giving instructions in the needs of the participant who will be provided the service; demonstrate the ability to provide services according to a plan of service; pass a criminal background check and must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter.

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Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>	
Developmental Disabilities Agencies	Department of Health and Welfare	<ul style="list-style-type: none"> - At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns 	
Respite Care Provider And Early Intervention Provider	Department of Health and Welfare	<ul style="list-style-type: none"> - At initial provider agreement approval or renewal - At least every two years, and as needed based on service monitoring concerns 	
Service Delivery Method. <i>(Check each that applies):</i>			
<input type="radio"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>			
Service Title:	Habilitative Supports		
Service Definition (Scope):			
<p>Habilitative Supports provides assistance to a participant with a disability by facilitating their independence and integration into the community. This service provides an opportunity for a participant to explore their interests, practice skills learned in other therapeutic environments, and learn through interactions in typical community activities.</p> <p>Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization and relationship building, and participation in leisure and community activities.</p> <p>This service is only provided in the participant's home or in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or therapy, nor are they intended to supplant the role of the primary caregiver.</p> <p>The supports provider must maintain a log of the habilitative support services in the participant's record documenting the provision of activities outlined in the plan of service. Supports that take place in both the home and community must ensure the participant is actively participating in age appropriate activities and is engaging with typical peers according to the ability of the participant.</p>			

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Limitations: - Habilitative Supports cannot be provided during the same time other services are being provided to a participant. - Habilitative Supports shall not duplicate other Medicaid reimbursed services.			
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):			
N/A			
Specify limits (if any) on the amount, duration, or scope of this service for (<i>chose each that applies</i>):			
○	Categorically needy (<i>specify limits</i>):		
X	Subject to individual budget maximums		
○	Medically needy (<i>specify limits</i>):		
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Developmental Disabilities Agency		Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.	Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide habilitative supports in a DDA: Must be at least 18 years of age; must be a high school graduate or have a GED; demonstrate the ability to provide services according to a plan of service; have received instructions in the needs of the participant who will be provided the service; pass a criminal background check; complete a competency course approved by the Department related to the support staff job requirements; and have six (6) months supervised experience working with children with developmental disabilities. Experience can be achieved in the following ways: i. Have previous work experience gained through paid employment, university practicum experience, or internship; or ii. Have on-the-job supervised experience gained through employment at a DDA with increased supervision. In addition to the habilitative support qualifications, staff serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: - Have transcribed courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education, or closely-related coursework; or - Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist.

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Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Early Intervention Provider			<p>Providers must be at least 18 years of age; must be a high school graduate or have a GED; demonstrate the ability to provide services according to a plan of service; have received instructions in the needs of the participant who will be provided the service; pass a criminal background check; complete a competency course approved by the Department related to the support staff job requirements; and have six (6) months supervised experience working with children with developmental disabilities. Experience can be achieved in the following ways:</p> <ul style="list-style-type: none"> -Have previous work experience gained through paid employment, university practicum experience, or internship; or -Have on-the-job supervised experience gained through employment at a DDA with increased supervision. <p>Staff serving infants and toddlers from birth to three (3) years of age must:</p> <ul style="list-style-type: none"> - Have transcribed courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education, or closely-related coursework; or - Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist.

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Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Developmental Disabilities Agencies	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns
Early Intervention Provider	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every two years, and as needed based on service monitoring concerns
Service Delivery Method. <i>(Check each that applies):</i>		
<input type="radio"/> Participant-directed	<input checked="" type="radio"/> Provider managed	
Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>		
Service Title:	Family Education	
Service Definition (Scope):		
<p>Family education is professional assistance to families to help them better meet the needs of the participant. It offers education to the parent/ participant's decision making authority that is specific to the individual needs of the family and child as identified on the plan of service. Family education is delivered to families to provide an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to their child's diagnoses. Family education may also provide assistance to the parent/participant's decision making authority in educating other unpaid caregivers regarding the needs of the participant.</p> <p>Family education providers must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. When family education is provided in a group setting, the group should consist of no more than five (5) participants' families.</p>		
Additional needs-based criteria for receiving the service, if applicable <i>(specify):</i>		
N/A		
Specify limits (if any) on the amount, duration, or scope of this service for <i>(chose each that applies):</i>		
<input checked="" type="radio"/>	Categorically needy <i>(specify limits):</i>	
	Subject to individual budget maximums.	
<input type="radio"/>	Medically needy <i>(specify limits):</i>	

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Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify)	Certification (Specify):	Other Standard (Specify):
Developmental Disabilities Agency		Developmental Disabilities Agency (DDA) certificate as described in Idaho Administrative Code.	Individuals must meet the minimum general training requirements defined in IDAPA rule "Developmental Disabilities Agencies", and in addition must meet the following qualifications to provide family education in a DDA: Must hold at least a bachelor's degree in a human services field from a nationally accredited university or college; must have one year experience providing care to children with developmental disabilities; must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide family education; and must complete a criminal history and background check. Additionally, each professional providing family education services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective.
Early Intervention Provider			<p>Provider must hold at least a bachelor's degree in a human services field from a nationally accredited university or college; must have one year experience providing care to children with developmental disabilities; must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide family education; and must complete a criminal history and background check. Additionally, each professional providing family education services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective.</p> <p>Providers of family education servicing infants and toddlers from birth to three (3) years of age must have a minimum of 240 hours of professionally-supervised experience with young children who have developmental disabilities and at least one (1) of the following:</p> <ul style="list-style-type: none"> - An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education - A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate or - A bachelor's or master's degree in special

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			education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ ECSE) from an accredited college or university.
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Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>		
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Developmental Disabilities Agencies	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every three years, and as needed based on service monitoring concerns
Early Intervention Provider	Department of Health and Welfare	- At initial provider agreement approval or renewal - At least every two years, and as needed based on service monitoring concerns
Service Delivery Method. <i>(Check each that applies):</i>		
Participant-directed	<input checked="" type="checkbox"/>	Provider managed
Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>		
Family-Directed Community Support Services		
Service Definition (Scope):		

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<p>Family-Directed Community Support Services provide goods and supports that are medically necessary and/or minimize the participant’s need for institutionalization and address the participant’s preferences for:</p> <ul style="list-style-type: none"> - Personal support to help the participant maintain health, safety, and basic quality of life. - Relationship support to help the participant establish and maintain positive relationships with immediate family members, friends, or others in order to build a natural support network and community. - Emotional support to help the participant learn and practice behaviors consistent with their goals and wishes while minimizing interfering behaviors. - Learning support to help a child to learn new adaptive skills or improve and expand their existing skills that relate to his identified goals - Non-Medical Transportation support to help the participant accomplish their identified goals. - Adaptive and therapeutic equipment address an identified medical or accessibility need in the service plan (improving and maintaining the participant’s opportunities for full membership in the community) and meet the following requirements: <ul style="list-style-type: none"> · A safe and effective treatment that meets acceptable standards of medical practice · Items needed to optimize the health, safety and welfare of the participant · The least costly alternative that reasonably meets the participant’s need · For the sole benefit of the participant · The participant does not have the funds to purchase the item or the item is not available through another source. <p>Adaptive and therapeutic equipment must also meet at least one of the following:</p> <ul style="list-style-type: none"> · maintain the ability of the participant to remain in the community, · enhance community inclusion and family involvement, · decrease dependency on formal support services and thus increase independence of the participant OR · provide unpaid family members and friends training in the use of the equipment to provide support to the participant. <p>Adaptive and therapeutic equipment are not otherwise covered under Durable Medical Equipment (DME). Services and equipment that are available through the Medicaid State plan as 1905(a) services for children per Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements are not allowed as payable under family-directed community support services. Experimental or prohibited treatments are excluded.</p>	
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):	
N/A	
Specify limits (if any) on the amount, duration, or scope of this service for (<i>chose each that applies</i>):	
<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):
	Subject to the individual budget amount.
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):

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Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Community Support Agency	If required to identify goods or supports. For example, a Community Support providing speech-language pathology must have a current speech-language pathology licensure.	If required to identify goods or supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.
Community Support Provider	If required for identified goods or supports. For example, a Community Support providing speech-language pathology must have current speech-language pathology license.	If required for identified goods and supports.	Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and statement of qualification to provide identified supports.

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Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):	
Community Support Agency	Participant and parent/decision-making authority Paid Support Broker (if applicable) Department of Health and Welfare (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement	
Community Support Provider	Participant and parent/ decision-making authority Paid Support Broker (if applicable) Department of Health and Welfare (during retrospective quality assurance reviews)	Initially and annually, with review of employment/vendor agreement	
Service Delivery Method. (Check each that applies):			
<input checked="" type="checkbox"/>	Participant-directed	<input type="checkbox"/>	Provider managed
Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):			
Service Title:	Financial Management Services		
Service Definition (Scope):			
<p>The Department will offer financial management services through any qualified fiscal employer agent (FEA) provider through a provider agreement. FEA providers will complete financial consultation and services for a participant who has chosen to family-direct their services in order to assure that the financial information and budgeting information is accurate and available to them as is necessary in order for successful family-direction to occur. Once the participant or the participant’s decision making-authority have entered into a written agreement, the FEA performs the following:</p> <p>A. Payroll and Accounting. Provides payroll and accounting supports to the participant that has chosen the family-directed community supports option;</p> <p>B. Financial Reporting. Perform financial reporting for employees of the participant;</p> <p>C. Financial Information Packet. Prepare and distribute a packet of information, including department approved forms for agreements, in order for the participant and family to hire their own staff;</p> <p>D. Time Sheets and Invoices. Process and pay timesheets for community support workers and support brokers, as authorized by the participant and parent/decision-making authority according to the participant’s Department authorized support and spending plan;</p> <p>E. Taxes. Manages and processes payment of required state and federal employment taxes for the participant's community support worker and support broker;</p>			

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<p>F. Payments for goods and services. Processes and pay invoices for goods and services, as authorized by the participant and parent/decision- making authority according to the participant’s support and spending plan;G. Spending information. Provides participant and parent/decision-making authority with reporting information and data that will assist the participant and parent/decision-making authority with managing the individual budget;</p> <p>H. Quality assurance and improvement. Participate in department quality assurance activities.</p> <p>FEA qualifications and requirements and responsibilities as well as allowable activities are described in Idaho Administrative Rules.</p>			
<p>Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):</p>			
<p>N/A</p>			
<p>Specify limits (if any) on the amount, duration, or scope of this service for (<i>chose each that applies</i>):</p>			
<input checked="" type="checkbox"/>	<p>Categorically needy (<i>specify limits</i>):</p> <p>Only participants who select the family-directed option may access this service. The FEA must not either provide any other direct services (including support brokerage) to the participant to ensure there is no conflict of interest; or employ the parent/decision-making authority of the participant or have direct control over the participant's choice. The FEA providers may only provide financial consultation, financial information and financial data to the participant and their parent/decision-making authority, and may not provide counseling or information to the participant and parent/decision-making authority about other goods and services.</p>		
<input type="checkbox"/>	<p>Medically needy (<i>specify limits</i>):</p>		
<p>Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):</p>			
<p>Provider Type (<i>Specify</i>):</p>	<p>License (<i>Specify</i>):</p>	<p>Certification (<i>Specify</i>):</p>	<p>Other Standard (<i>Specify</i>):</p>
Fiscal Employer/Agent			<p>Agencies that provide financial management services as a FEA must be qualified to provide such services as indicated in section 3504 of the Internal Revenue Code and in accordance with the requirements outlined in the signed provider agreement with the Department</p>
<p>Verification of Provider Qualifications (<i>For each provider type listed above. Copy rows as needed</i>):</p>			

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Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>	
Fiscal Employer/Agent	Department of Health and Welfare	At the time of application, as indicated by a readiness review to be conducted by the Department for all FEA providers and thereafter at least every three years by Department review.	
Fiscal Employer/Agent	Department of Health and Welfare	At the time of application, as indicated by a readiness review to be conducted by the Department for all FEA providers and thereafter at least every three years by Department review.	
Service Delivery Method. <i>(Check each that applies):</i>			
<input checked="" type="checkbox"/>	Participant-directed	<input type="checkbox"/>	Provider managed
Service Title:	Support Broker		
Service Definition (Scope):			
<p>Support brokers provide counseling and assistance for participants and their parent or decision making authority with arranging, directing, and managing services. They serve as the agent or representative of the participant to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. This includes providing participants and their parent/decision-making authority with any assistance they need for gathering and reviewing their budget and financial data and reports prepared and issued to them by the FEA. Practical skills training is offered to enable families to remain independent. Examples of skills training include helping families understand the responsibilities involved with directing services, providing information on recruiting and hiring community support workers, managing workers and providing information on effective communication and problem-solving. The extent of support broker services furnished to the participant and parent or decision-making authority must be specified on the support and spending plan. Support broker qualifications, requirements and responsibilities as well as allowable activities are described in IDAPA 16.03.13.135-136. Support broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant and parent or decision-making authority's needs and preferences. At a minimum, the support broker must:</p> <ul style="list-style-type: none"> - Participate in the family-centered planning process. 			

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- Develop a written support and spending plan with the participant and family that includes the supports the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three backup plans should a support fall out.
- Assist the participant and family to monitor and review their budget through data and financial information provided by the FEA.
- Submit documentation regarding the participant and parent/decision-making authority's satisfaction with identified supports as requested by the Department.
- Participate with Department quality assurance measures, as requested.
- Assist the participant and parent/decision-making authority with scheduling required assessments to complete the Department's annual re-determination process as needed, including assisting the participant and parent/decision-making authority to update the support and spending plan and submit it to the Department for authorization. In addition to the required minimum support broker duties, the support broker must be able to provide the following services when requested by the participant and parent/decision-making authority:
 - Assist the participant and parent/decision-making authority to develop and maintain a circle of support.
 - Help the participant and family learn and implement the skills needed to recruit, hire, and monitor community supports.
 - Assist the participant and parent/decision-making authority to negotiate rates for paid Community Support Workers.
 - Maintain documentation of supports provided by each Community Support Worker and participant and parent/ decision-making authority's satisfaction with these supports.
 - Assist the participant and parent/decision-making authority to monitor community supports.
 - Assist the participant and parent/decision-making authority to resolve employment-related problems.
 - Assist the participant and parent/ decision-making authority to identify and develop community resources to meet specific needs.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

N/A

Specify limits (if any) on the amount, duration, or scope of this service for (*choose each that applies*):

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<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
	Only participants who select the Family-Directed Option may access this service. Support brokers may not act as a fiscal employer agent, instead support brokers work together with the participant and parent/decision-making authority to review participant financial information that is produced and maintained by the fiscal employer agent.		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Support Broker			Specific requirements outlined in Idaho Administrative Code - IDAPA 16.03.13 include review of education, experience, successful completion of Support Broker training and ongoing education. The parent/decision-making authority can be an unpaid support broker for the participant and are subject to the same qualification requirements as paid support brokers.
Verification of Provider Qualifications (<i>For each provider type listed above. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):		Frequency of Verification (<i>Specify</i>):
Support Broker	Department of Health and Welfare		At the time of application, annual review of ongoing education requirement, and by participant and parent/decision-making authority when entering into employment agreement.
Service Delivery Method. (<i>Check each that applies</i>):			
<input checked="" type="checkbox"/>	Participant-directed	<input type="checkbox"/>	Provider managed

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2. Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians: There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS ; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Respite is the only State plan HCBS that may be provided by relatives of a participant. A parent/decision-making authority cannot furnish State plan HCBS, but other relatives may be paid to provide respite services whenever the relative is qualified to provide respite as defined in this application. There are numerous safeguards in place to ensure that payments are only made for services rendered including oversight by provider agencies, family-centered planning teams, circles of supports, fiscal/employer agent, and by the Department through review and approval of plan of services and retrospective quality assurance reviews.

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

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3. Additional Limits on Amount of Waiver Services

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

Not selected

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

Applicable - The State imposes additional limits on the amount of waiver services. When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. *(check each that applies)*

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above.*

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*

a) 1915(i) State Plan HCBS services included in the budget amount are respite, habilitative supports, family education, OR community support services under the family-directed services option. Therapeutic consultation and crisis intervention services are excluded from the budgets.

b) The state utilizes an individual budget model for children's developmental disabilities services that provides each child with an individual budget amount based on evidence-based research and level of care needs. The budget methodology includes a tiered approach using budget categories that range from addressing basic needs to intense early intervention needs.

The intent of the children's developmental disabilities budget methodology is to maximize

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budget distribution based upon the variable service needs of children with developmental disabilities. The Medicaid fee for service rates and estimated utilization of each service are used to develop the individual's budget. The budget methodology is based on a random sample analysis with a 95% confidence level. An Inventory of Individual Needs assessment was completed on a random sample of eligible children with developmental disabilities to identify trends in the population that could be used for budget setting purposes. This methodology was determined to be the most effective way to manage budgets, whereas historical utilization was found to be unreliable and not a true reflection of appropriate utilization.

The sample findings were applied to the general children's DD population, and the budgets were distributed based upon the service level needs of the participants and funds available. The children's budget methodology is driven by evidence-based research and is reflective of the children's continuum of services developed under the waiver services. The continuum of services creates a system based on needs. When children's needs become more involved they are able to access a wide array of services and the budget levels are increased accordingly.

The Department monitors the budgets on an ongoing basis to ensure that children's needs are accurately being reflected. The budget setting methodology is evaluated on an annual basis using tracking reports established by the Department. This information is used to help the state identify improvements if needed. The state has identified the following criteria for the 1915(i)State Plan HCBS benefit:

- \$4,900 budget*
- Children meeting developmental disabilities criteria who do not meet ICF/ID level of care*

The IAP contractor makes the final determination of a child's eligibility, based upon the assessments administered by the IAP. The purpose of the eligibility assessment is to determine a child's eligibility for the DD program including if the child qualifies for ICF/ID level of care, and assigning a budget amount based on the funding level criteria.

Eligibility determination must be completed initially and on an annual basis for waiver participants. This determination includes a functional assessment or review of the prior assessment to reflect the child's current level of functioning. Once eligibility is completed, the IAP must provide the results of the determination to the family by sending a notice with appeal rights.

c) Ongoing monitoring of the budget model, complaints, appeals, and participant outcomes are conducted by the Department to ensure that assigned budgets are sufficient to assure health and safety of participants in the community. If the Department determines that a change needs to be made to the budget methodology, participants will be sent notification of the change prior to implementation. The budget methodology is available on the children's developmental disabilities services website for families and providers, and is included in administrative code. Changes to administrative code regarding the budget methodology will be subject to public feedback as part of the rulemaking process.

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d) Families who believe that their child's assigned budget does not accurately reflect their needs may appeal the decision and request a fair hearing. Families may also submit an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services request if they feel the amount of services are not sufficient to meet the medical needs of their child. Services available under EPSDT are not subject to the child's budget.

e) A child's individual budgets will be re-evaluated at least annually. At the request of the family, the Department will also re-evaluate the set budget amount when there are documented changes that may support placement in a different budget category.

Families may request a re-evaluation at any point during the planning year by submitting the request to their case manager. The case manager will forward the request to the IAP, and a written notification will be sent to the family of the decision and the right to appeal.

The Department has also built safeguards into the 1915(i) benefit for outlier cases, where children who have complex conditions may require more specialized services or increased supports beyond what is accounted for in the budget. For this reason the waiver offers services that are not subject to a child's budget that are available for families where it is found the budgeted services may be insufficient to meet their child's needs.

Therapeutic consultation is a service that provides advanced assessments and planning for children who are not demonstrating outcomes with their current treatment. The case manager will work with the family to determine if this specialized service could benefit the child, and the cost of the service is excluded from the budget. The case manager may identify that additional services are needed for any number of reasons, some including recommendations from the family or service providers, changes in the child's condition, or during plan monitoring as part of progress review.

Crisis intervention services are also available outside of the child's budgets to act as a safeguard for children requiring additional support. The Department has a crisis network team that is utilized to case manage crisis situations. Crisis intervention can be provided by a developmental disability agency and assists the family when their child's behaviors are escalating. Crisis services under the waiver provide immediate remediation and up to 24 hours of support for children in crisis, and may be provided in the child's home or in a short term out of home placement. The case manager is informed of the need for these services in a number of ways, some including recommendations from the family or service providers, changes in the child's condition, a critical incident, or during plan monitoring as part of progress review.

f) Participants are notified of their eligibility for waiver services and given an annual individual budget at the time of their initial determination or annual re-determination. Each participant receives written notification of the set budget amount from the IAP. The notification includes how the participant may appeal the set budget amount decision. Individual budgets are re-evaluated annually by the IAP and written notifications of the set budget amount are sent annually.

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

Describe the limit and furnish the information specified above.

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Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. *(Select one):*

i	The State does not offer opportunity for participant-direction of State plan HCBS.
X	Every participant in State plan HCBS (or the participant’s decision-making authority) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
i	Participants in State plan HCBS (or the participant’s representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. <i>(Specify criteria):</i>

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

Idaho's family-direction option provides a more flexible system, enabling participants and their parent/decision-making authority to exercise more choice and control over the services they receive which helps them live more productive and participatory lives within their home communities. This option is provided within the existing system so that it is sustainable and reflects the value of this option for all participants and their parents/decision-making authorities who choose to direct their own services and supports. The process supports participant and parent/decision-making authority preferences and honors their desire to family-direct their own services; how and when supports and services are provided; and who will assist them in developing and monitoring a realistic support and spending plan that accurately reflects their individual wants and needs.

Once participants are determined eligible for State plan HCBS, an individualized budget is developed for each participant. The budget model provides participants with an individual budget and a maximum level of funding that varies according to individual needs, and allows for spending flexibility within the set budgeted dollars. The support need is determined from an evaluation completed using a uniform assessment tool. Upon completion of the assessment, the individualized budget is reviewed with the participant and parent/decision-making authority by the Department or its contractor.

Participants then have the option to choose Family-Directed Services (FDS). The FDS option allows eligible participants and their parent/decision-making authority to choose the type and frequency of supports they want, to negotiate the rate of payment, and to hire the person or agency they prefer to provide those supports. Participants and the parent/decision-making authority must use a support broker to assist them with the family-directed process. This can be accomplished in one of two ways:

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The family may choose to hire an approved support broker to perform specific duties as needed, or the parent/decision-making authority may choose to act as an unpaid support broker with the ability to perform the full range of support broker duties. If a parent/decision-making authority wishes to act as an unpaid support broker for the participant, they must complete the support broker training and be approved by the Department. Paid support broker services are included as part of the community support services that participants and their parent/decision-making authority may purchase out of their allotted budget dollars.

Support broker duties include planning, accessing, negotiating, and monitoring the family's chosen services to their satisfaction. They can assist families to make informed choices, participate in a family-centered planning process, and become skilled at managing their own supports. The support broker possesses skills and knowledge that go beyond typical service coordination. The support broker assists participants and parents/decision-making authorities to convene a circle of supports team and engages in a family-centered planning process. The circle of supports team assists participants and parents/decision-making authorities in planning for and accessing needed services and supports based on their wants and needs within their established budget.

The FDS option gives participants and their parent/decision-making authority the freedom to make choices and plan their own lives, authority to control the resources allocated to them to acquire needed supports, the opportunity to choose their own supports and the responsibility to make choices and take responsibility for those choices. Families and support brokers are responsible for the following:

- Accepting and honoring the guiding principles of family-direction to the best of their ability.
- Directing the family-centered planning process in order to identify and document support and service needs, wants, and preferences.
- Negotiating payment rates for all paid community supports they want to purchase.
- Developing and implementing employment/service agreements.

Families, with the help of their support broker, must develop a comprehensive support and spending plan based on the information gathered during the family-centered planning. The support and spending plan is reviewed and authorized by the Department and includes participant's preferences and interests by identifying all the supports and services, both paid and non-paid, and the participant's wants and needs to live successfully in their community.

Participants and their parent/decision-making authority choose support services, categorized as "family-directed community supports," that will provide greater flexibility to meet the participant's needs in the following areas:

My Personal Needs - focuses on identifying supports and services needed to assure the person's health, safety, and basic quality of life.

My Relationship Needs – identifies strategies in assisting an individual to establish and maintain relationships with immediate family members, friends, spouse, or other persons and build their natural support network.

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My Emotional Needs – addresses strategies in assisting an individual to learn and increasingly practice behaviors consistent with the person’s identified goals and wishes while minimizing interfering behaviors.

My Learning Needs - identifies activities that support an individual in acquiring new skills or improving established skills that relate to a goal that the person has identified.

Participants and their parent/decision-making authority choosing the Family-Directed Services option in Idaho are required to choose a qualified financial management services provider to provide Financial Management Services (FMS). The FMS provider is utilized to process and make payments to community support workers for the community support services contained in their support and spending plan. FMS providers have primary responsibility for monitoring the dollars spent in accordance with the itemized spending plan and for ensuring payment itemization and accuracy. Financial management service providers also manage payroll expenses including required tax withholding, unemployment/workers compensation insurance; ensuring completion of criminal history checks and providing monthly reports to the participant, parent/decision-making authority and support broker if applicable. Financial Management service providers offer services on behalf of the participant in accordance with Section 3504 of the IRS code and the IRS Revenue Procedure 70-6, which outlines requirements of financial management service providers who are fiscal employer agents.

3. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

X	Participant direction is available in all geographic areas in which State plan HCBS are available.
i	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit’s standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. <i>(Specify the areas of the State affected by this option):</i>

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
Community Support Services	X	X
Support Broker Services	X	X
Financial Management Services	X	X

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5. Financial Management. *(Select one):*

i	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
i	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.
X	<p>Financial Services are furnished through a third party entity.</p> <p style="text-align: center;"><i>Specify whether governmental and/or private entities furnish these services.</i></p> <p style="padding-left: 20px;"><input type="radio"/> Governmental entities</p> <p style="padding-left: 20px;"><input checked="" type="radio"/> Private entities</p>

6. Participant-Directed Plan of Care. *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual’s ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

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6. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

The Department assists participants and the parent/decision-making authority with this transition and assures that authorization for services under family-direction do not expire until new services are in place. The Department provides technical assistance and guidance as requested by participants and their parent/decision-making authority, support brokers, and circles of support. Transition from family-direction to traditional services will not take more than 120 days and in most cases will be accomplished in 60 to 90 days. This transition time is spent re-determining the LOC needs, development of a new plan, and review and authorization of the new plan. The participant remains in family-direction until this process is completed so that there is no interruption in services. If at any time there are health and safety issues, the Department works closely with the participant and parent/decision-making authority to ensure that the participant's health and safety is protected. This may include utilizing the Crisis Network Team to address any immediate crises and/or authorizing an emergency 120-day transition plan to assure a smooth transition from family-directed services to traditional services.

Only demonstrated danger to the participant's health and safety would result in the involuntary termination of the participant's use of family-direction. In these cases, the Department will work closely with the parent/decision-making authority and support broker to identify necessary changes to the plan of service, authorize emergency services if necessary, and facilitate any other activities necessary to assure continuity of services during this transition.

7. Opportunities for Participant-Direction

a. Participant-Employer Authority (individual can hire and supervise staff). *(Select one):*

j	The State does not offer opportunity for participant-employer authority.
X	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
○	Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide State plan HCBS. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
X	Participant/Common Law Employer. The participant (or the participant's decision-making authority) is the common law employer of workers who provide State plan HCBS. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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b. Participant–Budget Authority (individual directs a budget). *(Select one):*

i	The State does not offer opportunity for participants to direct a budget.
X	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. <i>(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):</i>
	The same budget methodology used for the traditional option is applied for the family-directed services option. See page 33 of this Supplement 1 to Attachment 3.1-A for the complete description.
	Expenditure Safeguards. <i>(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):</i>

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The participant and parent/decision-making authority's selected Fiscal Employer Agent will have the individual budget and the approved supports and services from the support and spending plan. They will send monthly statements to participants and their parent/decision-making authority on a monthly basis to inform them on the status of expenditures. The support broker will assist the family to review these statements to assure spending is on track. Employment agreements are developed for each community support worker that describe what is expected and how the support worker will be paid.

As part of the QA process, Medicaid staff monitors FEAs to assure that processes are in place to monitor these expenditures. Each fiscal agent is required to: 1) Have a system in place to perform a quarterly quality management (QM) analysis activity on a statistically significant sample of overall participant records; 2) Have documented, approved policies and procedures with stated timeframes for performing a quarterly quality management analysis activity on a statistically significant sample of overall participant records; 3) Have internal controls documented and in place for performing a quarterly QM analysis activity on a statistically significant sample of overall participant records; 4) Forward QM reports to the Department within thirty (30) working days from the end of each quarter. In addition to reviewing these quarterly reports, the Department also conducts a full service performance check on each fiscal agent provider at least every 3 years (all policies and procedures, and all the task and services as agreed upon in the provider agreement).

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Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Frequency of Analysis and Aggregation
Administrative Authority						
The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the program by exercising oversight of the performance of State Plan HCBS functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.	The number and percent of remediation issues that the state followed up on that were identified in the contract monitoring reports a. Numerator: number of remediation issues followed up on identified in the contract monitoring reports. b. Denominator: number of remediation issues identified in the contract monitoring reports.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Provider performance monitoring Sampling Approach: 100% Review of remediation issues	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
1915(i) Eligibility						
An evaluation for state plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	Number and percent of applicants for HCBS services who receive an eligibility assessment. a. Numerator: Number of applicants for HCBS services who received an eligibility assessment b. Denominator: Number of applicants for HCBS services	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual

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	<p>Number and percent of participants who received an annual redetermination of eligibility within 364 days of their previous eligibility assessment.</p> <p>a. Numerator: Number of participants who received an annual redetermination within 364 days of their previous eligibility assessment.</p> <p>b. Denominator: Number of participants who received an annual redetermination.</p>	<p>Data Source: Reports to State Medicaid Agency on delegated administrative functions</p> <p>Sampling Approach: 100% Review of annual redetermination of eligibility</p>	<p>The State Medicaid Agency is responsible for data collection/generation</p>	<p>Quarterly Annual</p>	<p>The State Medicaid Agency is responsible for data aggregation and analysis</p>	<p>Quarterly Annual</p>
<p>The processes and instruments described in the approved state plan for determining eligibility are applied appropriately</p>	<p>Number and percent of eligibility determinations criteria was determined according to policy</p> <p>a. Numerator: number of eligibility determinations that were determined according to policy</p> <p>b. Denominator: number of eligibility determinations</p>	<p>Data Source: Reports to State Medicaid Agency on delegated administrative functions</p> <p>Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with +/- 5% margin of error</p>	<p>The State Medicaid Agency is responsible for data collection/generation</p>	<p>Annual</p>	<p>The State Medicaid Agency is responsible for data aggregation and analysis</p>	<p>Annual</p>
Qualified Providers						
<p>The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to the approved State Plan standards prior to furnishing services.</p>	<p>Number and percent of initial certified HCBS providers who meet certification standards prior to providing services</p> <p>a. Numerator: number of initial providers who meet required licensure or certification standards prior to providing services.</p> <p>b. Denominator: number of initial providers</p>	<p>Data Source: Reports to State Medicaid Agency on delegated administrative functions</p> <p>Sampling Approach: 100% Review</p>	<p>The State Medicaid Agency is responsible for data collection/generation</p>	<p>Quarterly Annual</p>	<p>The State Medicaid Agency is responsible for data aggregation and analysis</p>	<p>Quarterly Annual</p>

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	<p>Number and percent of certified providers who continue to meet certification standards</p> <p>a. Numerator: number of providers who continue to meet certification standards b. Denominator: number of ongoing providers surveyed.</p>	<p>Data Source: Reports to State Medicaid Agency on delegated administrative functions</p> <p>Sampling Approach: 100% Review of providers who are surveyed in the year</p>	<p>The State Medicaid Agency is responsible for data collection/generation</p>	<p>Quarterly Annual</p>	<p>The State Medicaid Agency is responsible for data aggregation and analysis</p>	<p>Quarterly Annual</p>
<p>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 participants. b. Denominator: number of initial providers providing services</p>	<p>Data Source: Reports to State Medicaid Agency on delegated administrative functions</p> <p>Sampling Approach: 100% Review</p>	<p>The State Medicaid Agency is responsible for data collection/generation</p>	<p>Quarterly Annual</p>	<p>The State Medicaid Agency is responsible for data aggregation and analysis</p>	<p>Quarterly Annual</p>
	<p>Number and percent of HCBS providers who received a review every two years.</p> <p>a. Numerator: number of providers reviewed in the year b. Denominator: number of providers who were required to receive a review in the year</p>	<p>Data Source: Reports to State Medicaid Agency on delegated administrative functions</p> <p>Sampling Approach: 100% Review of providers required to receive a review in the year</p>	<p>The State Medicaid Agency is responsible for data collection/generation</p>	<p>Quarterly Annual</p>	<p>The State Medicaid Agency is responsible for data aggregation and analysis</p>	<p>Quarterly Annual</p>
<p>The state implements its policies and procedures for verifying that training is conducted in accordance with state requirements and the approved State Plan</p>	<p>Number and percent of HCBS providers that meet state requirements for training.</p> <p>a. Numerator: number of HCBS providers reviewed that meet state requirements for training. b. Denominator: number of HCBS providers reviewed.</p>	<p>Data Source: Reports to State Medicaid Agency on delegated administrative functions</p> <p>Sampling Approach: 100% Review of providers who were reviewed within the year</p>	<p>The State Medicaid Agency is responsible for data collection/generation</p>	<p>Quarterly Annual</p>	<p>The State Medicaid Agency is responsible for data aggregation and analysis</p>	<p>Quarterly Annual</p>

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Service Plan						
Service plans address all members' assessed needs (including health and safety risk factors) and personal goals either by the State Plan HCBS service or through other means	Number and percent of service plans that document participant's needs, goals, and risk factors as identified in the individual's assessment a. Numerator: number of plans reviewed that document participant's needs, goals, and risk factors as identified in the assessment b. Denominator: number of plans reviewed	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with +/- 5% margin of error	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual
The state monitors service plan development in accordance with its policies and procedures	Number and percent of service plans reviewed and authorized by the Department prior to the expiration of the current plan of service. a. Numerator: number of service plans that were reviewed and authorized by the Department prior to the expiration of the current plan of service. b. Denominator: number of service plans reviewed and authorized by the Department.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with +/- 5% margin of error	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
Service plans are updated or revised at least annually or when warranted by changes in the HCBS participant's needs.	Number and percent of service plans that are updated/ revised when requested and warranted by changes in the participant's needs/goals. a. Numerator: number of service plans that are updated/ revised when requested and warranted by changes in the participant's needs/ goals. b. Denominator: number of service plans reviewed that identified the need for changes.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with +/- 5% margin of error	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual
Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.	Number and percent of service plans that indicate services were delivered consistent with the service type, scope, amount, duration and frequency approved on service plans. a. Numerator: number of plans reviewed that indicate services were delivered consistent with the approved plans. b. Denominator: number of plans reviewed.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with +/- 5% margin of error	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual

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Participants are afforded choice Between/among services and providers.	Number and percent of participants reviewed who reported they were given a choice when selecting service providers. a. Numerator: number of participants reviewed who reported they were given a choice when selecting service providers. b. Denominator: number of participants reviewed.	Data Source: Analyzed collected data Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with +/- 5% margin of error	The State Medicaid Agency is responsible for data collection	Quarterly	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly
	Number and percent of participants who reported they were given a choice when selecting services. a. Numerator: Number of participants who indicated they were given a choice between services b. Denominator: Number of participants reviewed.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with +/- 5% margin of error	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual
Health and Welfare						
The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	Number and percent of reported incidents of abuse, neglect or exploitation that follow up was completed within policy timelines a. Numerator: Number of reported incidents related to abuse, neglect or exploitation where action/resolution was completed within policy b. Denominator: Number of reported incidents related to abuse, neglect or exploitation	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% Review of critical reports	The State Medicaid Agency is responsible for data collection/generation	Monthly Quarterly Annual Continuously and ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly
	Number and percent of participant and/or family who received information/education about how to report abuse, neglect, exploitation and other critical incidents. a. Numerator: Number of participants or family who received information/education about how to report b. Denominator: Number of participants receiving services	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% review	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual

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	Number and percent of service plans with restrictive interventions (including restraints and seclusion) that were approved according to criteria. a. Numerator: Number of service plans with restrictive interventions that were approved according to criteria. b. Denominator: Number of service plans reviewed with restrictive interventions.	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% of service plans reviewed with restrictive interventions.	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
Financial Accountability						
The State Medicaid Agency maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	Number and percent of claims paid according to the posted fee schedule a. Numerator: Number of claims paid according to the posted fee schedule b. Denominator: Paid claims (by procedure code) for one week of each calendar quarter	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with +/- 5% margin of error.	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
	Number and percent of posted rates that are compared to the rate methodology a. Numerator: Posted rates compared to the rate methodology b. Denominator: Approved rate methodology	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% review of billing for a week period on an annual basis	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual
	Number and percent of claims paid to providers of Children's 1915(i) services a. Numerator: Paid claims to providers enrolled to furnish Children's 1915(i) services b. Denominator: Paid claims to providers of 1915(i) services	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: 100% review of billing for a week period on an annual basis	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
	Number and percent of unduplicated participants utilizing Children's 1915(i) services a. Numerator: Number of unduplicated participants with a paid claim for 1915(i) services b. Denominator: Number of unduplicated participants eligible for 1915(i) services	Data Source: Reports to State Medicaid Agency on delegated administrative functions Sampling Approach: Representative sample of child participants receiving HCBS services. Confidence interval = 95% with +/- 5% margin of error.	The State Medicaid Agency is responsible for data collection/generation	Quarterly Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly Annual
HCBS Settings						
Settings meet the home and community-based setting requirements as specified in accordance with 42 CFR 441.701(a) (1) and (2).	Number and percent of HCBS settings who are in compliance with HCBS regulations a. Numerator: Number of HCBS providers who meet compliance standards b. Denominator: Number of HCBS providers sampled to determine compliance	Data Source: Reports to the State Medicaid Agency on delegated administrative functions. Sampling Approach: 100% of reviewed HCBS providers.	The State Medicaid Agency is responsible for data collection/generation	Annual	The State Medicaid Agency is responsible for data aggregation and analysis	Annual

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System Improvement:

(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)

Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles	Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
<ul style="list-style-type: none"> * CSOR results are gathered; * Regional complaints and incident reports are investigated * Individual plans of service are reviewed by the Department 	Quality Management Staff	This is a group of staff across seven regions of Idaho, with knowledge of quality improvement interventions, and who are responsible for collecting and reporting data to the Department.	Ongoing	Data is gathered and submitted to the Department's analyst.
<ul style="list-style-type: none"> * Results of CSOR are reviewed and analyzed, and tabulated; * Complaints and Critical Incidents are reviewed analyzed, and tabulated * Plan of service information is analyzed 	Department Analyst	This is department staff identified that lead statewide data collection activities, analysis, and reporting activities related to quality management. This staff is responsible for creating and implementing data collection tools.	Ongoing	The analyzed data is presented to the QA team for review and prioritization.
<ul style="list-style-type: none"> * Quarterly meetings: Quarterly the committee reviews analyzed data to develop recommendations for program improvements, and reviews actions taken and progress made toward implementing previous approved system improvements. * Annual meeting: Meets annually to prioritize findings and develop recommendations for specific system improvements for the coming year. This recommendation will be submitted to administration for approval and assignment. 	Quality Management Team	The QM team is responsible for steering the quality assessment and improvement process, and issues related to parallel data collection. It is responsible for formally recommending specific program improvements to Department administration.	Quarterly	Annual QM report is submitted to administration.
<ul style="list-style-type: none"> * Quarterly QM Report * Annual QM Report 	FACS DD Policy Program Manager	FACS DD policy program manager takes overall responsibility for leading team members, finalizing quarterly and yearly QM reports, leading the process of prioritizing needs for system improvements, and implementing approved system improvements.	Quarterly and Yearly Report	Overall data findings and recommendations are submitted to the QM Team for review prior to finalization.

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1915(i) State plan Home and Community-Based Services Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals to add as set forth below:

1. **Services.** (Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):

Adult -Developmental Therapy
Adult – Community Crisis Supports

2. **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** (Select one):

<input type="radio"/>	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program (<i>select one</i>):	
<input checked="" type="checkbox"/>	The Medical Assistance Unit (<i>name of unit</i>):	Bureau of Developmental Disability Services
<input type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit (<i>name of division/unit</i>) <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>	
<input type="radio"/>	The State plan HCBS benefit is operated by (<i>name of agency</i>)	
A separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

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4. Distribution of State plan HCBS Operational and Administrative Functions.

(By checking this box the State assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (check each that applies):

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Eligibility evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3 Review of participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

The Department contracts with an Independent Assessment Provider (IAP) to complete level of care determinations and assign individualized budgets.

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(By checking the following boxes the State assures that):

5. **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
- related by blood or marriage to the individual, or any paid caregiver of the individual
 - financially responsible for the individual
 - empowered to make financial or health-related decisions on behalf of the individual
 - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

N/A

6. **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
7. **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
8. **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	July 1, 2013	June 30, 2014	2732
Year 2	July 1, 2014	June 30, 2015	2841
Year 3	July 1, 2015	June 30, 2016	2884
Year 4	July 1, 2016	June 30, 2017	2929
Year 5	July 1, 2017	June 30, 2018	2973

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2. **Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. **Medicaid Eligible.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Level (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act.)

2. **Income Limits.**

In addition to providing HCBS State plan services to individuals described in item 1 above the State is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for home and community-based services under the needs based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the federal poverty level or who are eligible for home and community based services under a waiver approved for the State under section 1915(c), (d) or (e) or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income benefit rate (as described in Attachment 2.2A, pages 23(f) of the state plan.).

The State covers all individuals described in items 2(a) and 2(b) as described in Attachment 2.2-A, of the state plan

The State covers only the following group individuals described below (complete 2(a) or 2(b)): As specified in Attachment 2.2-A of the state plan.

2.(a) Individuals not otherwise eligible for Medicaid who meets the needs based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services.

2(b) Individuals who would meet the criteria for a 1915(c) or 1115 waiver. The State covers all of the individuals described in item 1(b) as specified in Attachment 2.2A of the state plan.

Specify the 1915(c) Waiver/Waivers CMS Base Control Number/Numbers for which the individual would be eligible:

Idaho Developmental Disabilities Waiver. Waiver Number ID.0076

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Specify the name(s) or number(s) of the 1115 waiver(s) for which the individual would be eligible:

NA

3. Medically Needy. *(Select one):*

<input checked="" type="checkbox"/>	The State does not provide State plan HCBS to the medically needy.
<input type="checkbox"/>	The State provides State plan HCBS to the medically needy <i>(select one):</i>
<input type="checkbox"/>	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
<input type="checkbox"/>	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed *(select one):*

<input type="checkbox"/>	Directly by the Medicaid agency
<input checked="" type="checkbox"/>	By Other <i>(specify State agency or entity with contract with the State Medicaid agency):</i> The Department's contracted Independent Assessment Provider, Idaho Center for Disabilities Evaluation (ICDE)

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

Independent Assessment Providers who provide level of care determinations must be a Qualified Intellectual Disability Professionals (QIDP) who meets qualifications specified in the Code of Federal Regulations, Title 42 section 483.430.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Adults applying for 1915(i) services will submit an Eligibility Application for Adults with Developmental Disabilities to the Bureau of Developmental Disability Services (BDDS) in the region in which they live.

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Within three (3) days of receiving the application for services, BDDS verifies if the participant is financially eligible for Medicaid. After verifying a participant's financial eligibility, the application is forwarded to the Department's contractor, Idaho Center for Disabilities Evaluation (ICDE), to determine if the participant meets Needs-based HCBS Eligibility Criteria.

The ICDE is responsible for completing the eligibility determination process within thirty (30) days of receiving an application. This process includes the following:

- a. ICDE requests a current physician's health and physical report (completed within the prior six (6) months) and Nursing Service and Medication Administration form from the participant's primary care physician.
- b. ICDE contacts the participant's person-centered planning (PCP) team to identify who will serve as a respondent for the initial eligibility assessments to be completed by ICDE. The PCP team is responsible for identifying a respondent who has knowledge about the participant's current level of functioning. The participant is required to accompany the respondent to a face-to-face meeting with ICDE to complete the initial eligibility assessment process.
- c. During the face-to-face meeting with ICDE, the respondent for the participant will participate in completing the Scales of Independent Behavior Revised (SIB-R) and Medical, Social, Developmental Assessment Summary. These assessments, in addition to other required documentation, are used to verify Needs-based HCBS Eligibility Criteria:
- d. At the time of the face-to-face meeting, ICDE completes an Inventory of Individual Needs with the respondent. This inventory is used to calculate an initial budget according to the participant's functional abilities, behavioral limitations, medical needs and other individual factors related to the person's disability.
- e. ICDE communicates eligibility determinations and calculated budgets to the participant/guardian through a written Notice of Decision. Participants/guardians who do not agree with a decision regarding eligibility or the calculated budget may request an administrative hearing.
- f. ICDE maintains all documentation associated with the initial eligibility assessment process in an electronic file in the ICDE database. Additionally, ICDE uploads the Eligibility Application, Eligibility Assessments, Eligibility Notices and any other documentation used to support approval of eligibility into the Member's case file in the Department's MMIS system.

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PROCESS FOR ANNUAL REEVALUATION

The annual reevaluation process is the same as the initial evaluation process, except for the following differences:

- A new Eligibility Application for Adults with Developmental Disabilities does not have to be submitted by the participant on an annual basis.
- If a change in the participant's income results in the termination of Medicaid financial eligibility, claims submitted for reimbursement by providers after the date of ineligibility will not be paid. Medicaid providers are required to verify participant eligibility prior to providing services as approved on the annual Individual Service Plan (ISP).
- ICDE is only required to complete a new SIB-R assessment or update the Medical, Social, Developmental Assessment Summary when it is determined that the existing documentation does not accurately describe the current status of the participant. ICDE will make a clinical determination regarding the need for a new/updated assessment based on information provided at the annual eligibility determination by a respondent selected by the participant's person-centered planning (PCP) team. This respondent is someone the participant and their person-centered planning team have identified as the person who is most qualified to provide current information regarding the participant's medical, functional, and behavioral needs.
- Unless contra-indicated, the participant is required to attend the annual re-determination meeting. Any comments or questions voiced by the participant during this meeting will be addressed and considered by the Independent Assessment Provider (IAP) completing the annual eligibility assessment.
- Information from the Inventory of Individual Needs that is completed with the respondent is included with the Notice of Decision sent to the participant regarding their annual eligibility determination. If the participant and their PCP team disagree with any of the responses contained on the Inventory, the participant is afforded the opportunity to appeal the responses through an administrative hearing process.

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4. **Needs-based HCBS Eligibility Criteria.** (By checking this box the State assures that): Needs-based criteria are used to evaluate and reevaluate whether an adult individual is eligible for State plan HCBS.

The criteria take into account the individual’s support needs, and may include other risk factors:
(Specify the needs-based criteria):

- The individual requires assistance due to substantial limitations in three or more of the following major life activities – self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self sufficiency;
- The individual has a need for combination and sequence of special interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned and coordinated due to a delay in developing age appropriate skills occurring before the age of 22.

5. **Target Group(s).** Under the waiver of Section 1902 (a) (10)(B) of the Act, the State limits this section of 1915(i) state plan options services to a group or subgroups of individuals:

Adult participants age 18 or older diagnosed with Developmental Disabilities as defined in Idaho Code Section 66-402.

6. **Needs-based Institutional and Waiver Criteria.** (By checking this box the State assures that):

There are needs-based criteria for receipt of institutional services and participant in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. (Complete chart below to summarize the needs-based criteria for state Plan HCBS and corresponding more stringent criteria for each of the following institutions):

State plan HCBS Needs-based Eligibility Criteria	NF (&NF LOC Waivers)	ICF/ID (&ICF/ID LOC Waivers)	Applicable Hospital* LOC (& Hospital LOC Waivers)
The individual requires assistance due to substantial limitations in three or more of the following major life activities – self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency and	Idaho has developed a Uniform Assessment Instrument (UAI) as the basis of the nursing facility level of care instrument. The UAI measures deficits in ADLs, IADLs, Behavioral and Cognitive Functioning. A score of 12 points is needed to demonstrate NF LOC. Idaho Administrative Procedure defines this in IDAPA 16.03.10.322.04-.08, “Medicaid Enhanced Plan Benefit.”	In addition to being part of the Target Group described in this SPA and having substantial limitations outlined in the HCBS Needs Based Criteria, the individual must be determined to need consistent, intense and frequent services by meeting the following criteria:	The State uses criteria defined in 42 CFR 440.10 for inpatient hospital services.

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<p>The individual has a need for combination and sequence of special interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned and coordinated due to a delay in developing age appropriate skills occurring before the age of 22.</p>	<p>In determining need for nursing facility care an adult must require the level of assistance according to the following formula:</p> <p><u>Critical Indicator - 12 Points Each.</u></p> <p>a. Total assistance with preparing or eating meals. b. Total or extensive assistance in toileting. c. Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking.</p> <p><u>High Indicator - 6 Points Each.</u></p> <p>a. Extensive assistance with preparing or eating meals. b. Total or extensive assistance with routine medications. c. Total, extensive or moderate assistance with transferring. d. Total or extensive assistance with mobility. e. Total or extensive assistance with personal hygiene. f. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI).</p> <p><u>Medium Indicator - 3 Points Each.</u></p> <p>a. Moderate assistance with personal hygiene. b. Moderate assistance with preparing or eating meals. c. Moderate assistance with mobility. d. Moderate assistance with medications. e. Moderate assistance with toileting. f. Total, extensive, or moderate assistance with dressing. g. Total, extensive or moderate assistance with bathing. h. Extensive or moderate assistance with supervision from Section II No. 18 of the UAI.</p>	<p>The individual must require a certain level of care. Persons living in the community must require the level of care provided in an ICF/ID, including active treatment, and in the absence of available intensive alternative services in the community, would require institutionalized, other than services in an institution for mental disease, in the near future: and</p> <p>Persons may qualify based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on the SIB-R would qualify; or</p> <p>Persons may qualify based on their Maladaptive Behaviors:</p> <ul style="list-style-type: none"> • A minus twenty-two (-22) or below score. Individuals may qualify for ICF/ID level of care based on maladaptive behavior. Adults will be eligible if their general Maladaptive index on the SIB-R or subsequent revision is minus twenty-two (-22) or less • Above a Minus twenty-two (-22) score. Individuals who score above minus twenty-two (-22) may qualify for ICF/ID level of care if they engage in aggressive or self-injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and the person requires active treatment to control or decrease the behavior; or <p>Persons may qualify based on a combination of functional and maladaptive behaviors. Persons may qualify for ICF/ID level of care if they display a combination of criteria at a level that is significant. For persons Sixteen Years of Age or Older an overall age equivalency up to eight and one-half (8.5) years is significant in the area of functionality when combined with a general maladaptive index on the SIB-R from minus seventeen (-17), up to minus twenty-two (-22) inclusive; or</p>	
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		<p>Persons may qualify based on a Persons may qualify based on their Medical Condition. Individuals may meet ICF/ID level of care based on their medical conditions if the medical condition significantly affects their functional level/capabilities and if it can be determined that they are in need of the level of services provided in an ICF/ID, including active treatment services.</p>	
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7. **Reevaluation Schedule.** Needs-based eligibility reevaluations are conducted at least every twelve months.

8. **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

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9. **Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:
- (i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or
 - (ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

Home and Community Based Services (HCBS) are designed to allow participants with developmental disabilities to live in home or community settings. Idaho makes these services available to eligible participants in order to provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, maintain health and safety and promote community integration

Prior to receiving State plan HCBS benefits, the Department or its contractor must verify that the participant resides in the community. As outlined in Idaho Statute and IDAPA, community residential service providers are required to facilitate the individual's full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, in the same manner as individuals without disabilities.

Residential settings, other than an individual's home/apartment or the home/apartment of a non-paid care provider, that will be approved as community living include:

- **Certified Family Home (CFH)**
 - A CFH is a private home setting in which a home care provider assists the participant with activities of daily living, provides protection and security, and encourages the participant toward independence. CFHs must assist the individual with establishing relationships and connecting with their community,
 - The Department monitors Certified Family Homes through the certification process described in Idaho Administrative Code. Certification for CFHs is required the year after the initial home certification study and at least every 24 months thereafter.
- **Residential Assisted Living Facility (RALF)**
 - A RALF is a community-based facility which provides a home-like environment that includes full access to amenities typically available in a home. A RALF must be of such character as to enhance normalization and integration of residents into the community.
 - The Department monitors RALFs through the certification process described in Idaho Administrative Code. Certification for RALFs is required within 90 days from the initial licensure followed by a survey within 15 months. Facilities receiving no core issue deficiencies during both the initial and the subsequent survey will enter a three year survey cycle.

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Idaho Statute requires that Certified Family Homes and Residential Assisted Living Facilities provide a safe and homelike environment within a participant's own community. Statute requires that these homelike environments must:

- focus on integrated community living and recognize the capabilities of individuals to direct their own care.
- allow residents the opportunity to work, be involved in recreation activities and education opportunities.
- ensure that employment, recreational and educational opportunities for people with disabilities shall be offered in the most integrated setting consistent with their needs

Idaho requires that all Home and Community Based setting qualities in Certified Family Homes and Residential Assisted Living Facilities are met including:

- the participant's ability to manage their personal funds
- participation in social, religious, and community activities
- participant control of their health-related services
- participant participation in the person centered planning process including making decisions related to employment and work in competitive integrated settings
- an individual's choice and control regarding daily living activities
- the ability to personalize his/her environment
- individual choice of who and when they wish to communicate and interact
- choice of roommates when sharing units or bedrooms
- an individual's right to being treated with dignity and respect
- right to privacy (with regard to accommodations, medical and other treatment, written and telephone communications, visits and meetings of family and resident groups)
- the right to be free from coercion, restraints, restrictive interventions, and seclusion
- the right to privacy in the sleeping or living unit including lockable doors, with appropriate person(s) having keys

In the case of CFH and RALF providers, specific physical space can be owned, rented or occupied under another enforceable agreement by the individual receiving services. Residents must be granted all rights and protections established by Idaho law. The resident has the right to written advanced notice prior to non-emergency transfer as agreed to by the resident and the provider in the admission agreement.

No provider owned or controlled residential settings identified in this SPA are:

- located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
- located in a building on the grounds of or immediately adjacent to a public institution; or
- located in a building on the grounds of or immediately adjacent to disability-specific housing.

It is noted that Idaho will through its system of oversight and remediation resolve issues when identified. Idaho monitors that setting requirements are met through the person centered planning process, licensing and certification activities and participant experience surveys. If a rule violation is identified, action will depend on the severity. Action could range from technical assistance, a corrective action plan, or termination of a provider agreement.

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Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1. There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
 - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
 - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
 - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
 - An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
 - If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
 - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. Based on the independent assessment, the individualized plan of care:
 - Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
 - Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
 - Prevents the provision of unnecessary or inappropriate care;
 - Identifies the State plan HCBS that the individual is assessed to need;
 - Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
 - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
 - Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.**
There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS.
(Specify qualifications):

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At a minimum, individuals conducting the independent assessment must meet the requirements for a Qualified Intellectual Disability Professional (QIDP) in accordance with 42 CFR 483.430. QIDP requirements include:

- a. Having at least (1) year experience working directly with persons with mental retardation or other developmental disabilities or;
- b. Being licensed as a doctor of medicine or osteopathy, or as a nurse, or;
- c. Having at least a bachelor's degree in one of the following professional categories: psychology, social work occupational therapy, speech pathology, professional recreation therapy or other related human services professions.
- d. Have training and experience in completing and interpreting assessments

- 4. Responsibility for Plan of Care Development.** There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. (*Specify qualifications*):

At a minimum, a paid plan developer developing a plan of care must meet service coordination qualifications outlined in IDAPA 16.03.10.729.

- Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator.
- Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department.
- Service coordinators must have a minimum of a Bachelor's degree in a human services field from a nationally accredited university or college and have twelve (12) months supervised work experience with the population being served; or be a licensed professional nurse (RN); and have twelve (12) months' work experience with the population being served. When an individual meets the education or licensing requirements but does not have the required supervised work experience, the individual must be supervised by a qualified service coordinator while gaining the required work experience.
- Service coordination agencies must verify that each service coordinator and paraprofessional they employ or with whom they contract has complied with IDAPA 16.05.06, Criminal History and Background Checks.
- The total caseload of a service coordinator must assure quality service delivery and participant satisfaction.

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- 5. Supporting the Participant in Plan of Care Development.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

During the assessment process, participants are provided with a list, organized by geographic area, of plan developers in the State of Idaho. The list also includes website links that provide helpful resources for participants, guardians, family members and person centered team members.

The plan of service is developed by the participant and their person centered planning team. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. With the participant's consent, the person-centered planning team may include family members, guardian, or individuals who are significant to the participant. A plan developer's responsibility for developing a service plan using a person-centered planning process is supported by IDAPA 16.03.10.730.-731.

If limits for targeted service coordination are reached, additional hours for person centered planning and needed addendums can be authorized by the Department in those situations where the participant demonstrates a health and safety need.

- 6. Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

During the assessment process, participants are provided with a list, organized by geographic area, of all approved providers in the state of Idaho. The list also includes website links that provide helpful resources for participants, guardians, family and person centered team members.

In addition, participants are provided with resources on interviewing potential providers and are encouraged to contact multiple providers to identify the provider that can best meet their needs. The provider list includes a statement that the participant may choose any willing and available provider in the state.

Participants are informed that the selection of a provider is their choice and that they may choose to change providers at any time. The participant's plan developer is available to assist a participant in selecting or changing service providers at the participant's or guardian's request.

Unless the participant has a guardian with appropriate authority, the participant, together with their person centered planning team, will make decisions regarding the type and amount of services required. The service coordinator is responsible for discussing service alternatives with the participant and must document that the participant has made a free choice of direct service providers and living arrangement. Service providers must ensure that the service type and settings are based on participant needs, interests or choices.

Participants have the right to review a list of other providers that may be available to meet his needs.

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7. Process for Making Plan of Care Subject to the Approval of the Medicaid Agency. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

All proposed Individual Support Plans and addendums must be submitted to the Department for review, approval and prior authorization. No claims for HCBS services will be paid without prior authorization. MMIS will not reimburse claims for HCBS services unless prior authorized in the MMIS system.

Medicaid has operational processes that optimize participant independence, community integration and choice in daily living. These processes include the requirement for HCBS benefits to be requested through a participant’s plan. The plan is developed by the participant through a person centered planning process and prior authorized by Medicaid. This prior authorization process is to ensure provision of services that enhance health and safety, promote participant rights, self-determination and independence according to IDAPA 16.03.10.507.

8. Maintenance of Plan of Care Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

<input checked="" type="checkbox"/> Medicaid agency	<input type="checkbox"/> Operating agency	<input type="checkbox"/> Case manager
<input checked="" type="checkbox"/> Other (<i>specify</i>):		

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Services

1. State plan HCBS: Developmental Therapy

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>	
Service Title:	Developmental Therapy
Service Definition (Scope):	
<p>Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy services must be delivered by Developmental Specialists or paraprofessionals based on a comprehensive developmental assessment completed prior to the delivery.</p> <ul style="list-style-type: none">• Areas of service. These services must be directed toward the rehabilitation or habilitation of physical or mental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency.• Age-appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate.• Tutorial activities and educational tasks are excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability.• Settings for developmental therapy. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices.• Staff-to-participant ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. Additional staff must be added, as necessary, to meet the needs of each individual served.• Community-based services must occur in integrated, inclusive settings and with no more than three (3) participants per qualified staff at each session.• Participants living in a certified family home must not receive home-based developmental therapy in a certified family home	

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Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):			
N/A			
Specify limits (if any) on the amount, duration, or scope of this service for (<i>chose each that applies</i>):			
<input checked="" type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
	Developmental therapy benefits limitation is 22 hours per week.		
	A legally responsible individual (e.g., a parent of minor child or a spouse) may not be paid for the provision of Developmental Therapy services.		
	A DDA may not hire the parent or legal guardian of a participant to provide services to the parent's or legal guardian's child.		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Developmental Disabilities Agency		Developmental Disabilities Agency (DDA) certificate as described in IDAPA 16.03.21	Agencies providing Developmental therapy must meet the staffing requirements and provider qualifications defined in IDAPA rule 16.03.21.400-499
Verification of Provider Qualifications (<i>For each provider type listed above. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):		Frequency of Verification (<i>Specify</i>):
Developmental Disabilities Agencies	Department of Health and Welfare		<ul style="list-style-type: none"> • At initial provider agreement or renewal • At least every three years, and as needed based on service monitoring concerns
Service Delivery Method. (<i>Check each that applies</i>):			
<input type="checkbox"/>	Participant-directed		<input checked="" type="checkbox"/> Provider managed

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2. State plan HCBS: Community Crisis Support

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>	
Service Title:	Community Crisis Support
Service Definition (Scope):	
<p>Community crisis supports are interventions for adult participants who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation or other emergencies. If a participant experiences a crisis, community crisis supports can be offered to assist the participant out of the crisis and develop a plan that mitigates risks for future instances.</p> <p>These individualized interventions are to ensure the health and safety of the participant and may include, but are not limited to: referral of the participant to community resources to resolve the crisis, direct consultation and clinical evaluation of the participant, training and staff development related to the needs of a participant, and/or emergency back-up involving the direct support of the participant in crisis.</p> <p>Community crisis supports are a benefit authorized to support a participant when the normal support structure fails. During times of crisis, service hours can be authorized when existing prior authorized services have been exhausted or are not appropriate for addressing the crisis. Crisis supports are only approved when support is not available to stabilize the participant through other sources.</p> <p>Community crisis supports are based on a crisis plan that outlines interventions used to resolve the crisis. After community crisis supports are provided, the crisis provider must supply the Department with documentation of the crisis outcome, identification of factors contributing to the crisis and a proactive strategy that will address the factors that resulted in a crisis in order to minimize the opportunity for future occurrences.</p>	
Additional needs-based criteria for receiving the service, if applicable <i>(specify):</i>	
Participant is at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies.	

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Specify limits (if any) on the amount, duration, or scope of this service for <i>(chose each that applies)</i> :	
<input checked="" type="checkbox"/>	<p>Categorically needy <i>(specify limits)</i>:</p> <p>Community crisis support is limited to a maximum of 20 hours during any consecutive five day period.</p> <p>In order to initiate a request for community crisis supports, the targeted service coordinator, in coordination with the person centered planning team, submits a request for community crisis supports to the Department. The Department case manager will review the request to ensure that the supports requested are not duplicative of other services being delivered to the participant. Community crisis supports will only be approved if all service hours previously prior authorized that may be appropriate to address the crisis have already been exhausted.</p> <p>When Community Crisis Supports has been accessed, the proactive strategy used to address the factors that resulted in a crisis should be incorporated as goals into the participant's person centered plan of service.</p> <p>Community crisis support may be retroactively authorized within seventy-two hours of providing the service if there is a documented need for immediate intervention, no other means of support are available and the services are appropriate to rectify the crisis.</p> <p>Participants who are not currently receiving developmental disability services may receive community crisis supports after completing an abbreviated person-centered planning process. In these cases, after eligibility for the service is determined, the participant and their planning team will develop a crisis plan to address the immediate crisis. This crisis plan will subsequently be incorporated into the overall person centered planning process and development of the initial DD plan of service.</p> <p>A legally responsible individual (e.g., a parent of minor child or a spouse) may not be paid for the provision of Community Crisis services</p>
<input type="checkbox"/>	<p>Medically needy <i>(specify limits)</i>:</p>

Provider Qualifications <i>(For each type of provider. Copy rows as needed):</i>			
Provider Type <i>(Specify)</i> :	License <i>(Specify)</i> :	Certification <i>(Specify)</i> :	Other Standard <i>(Specify)</i> :
Behavioral Consultation			Behavioral Consultation Providers must meet provider qualifications as outlined in IDAPA 16.03.10.705.12
Supported Employment Services			Supported Employment Providers must meet provider qualifications as outlined in 16.03.10.705.05

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Residential Habilitation Agency		Certificate as described As described in IDAPA 16.04.17 and 16.03.705	
Certified Family Home		Certified Family Home certificate as described in IDAPA at 16.03.19	
Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>		Frequency of Verification <i>(Specify):</i>
Behavioral Consultation	Department of Health and Welfare		At least every two years
Supported Employment Services	Department of Health and Welfare		At least every two years
Residential Habilitation Agency	Department of Health and Welfare		Residential habilitation providers are surveyed when they seek renewal of their certificate. The Department issues certificates that are in effect for a period of no longer than three years
Certified Family Home	Department of Health and Welfare		Certification for Certified Family Homes is required the year after the initial home certification study and at least every twenty-four (24) months thereafter.
Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

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2. **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS ; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Idaho does not allow payment for Adult Developmental Therapy or Community Crisis Supports provided by persons who are relatives of the individual.

Legally responsible individuals or legal guardians may be paid providers of Community Crisis Supports. Community crisis support is only authorized if there is a documented need for immediate intervention related to an unanticipated event, circumstance or life situation that places a participant at risk of at least one of the following: loss of housing, loss of employment or income, incarceration, physical harm, family altercation, or other emergencies. In order to closely monitor this service, authorization is limited to a maximum of twenty hours during any consecutive five day period. Payment is authorized based on a crisis support plan and assessment. During the authorization process, Department Care Managers review the plan to ensure that services authorized do not duplicate any other paid Medicaid services. If applicable, guardian papers are available to the Care Manager at the time the plan is review and approved to ensure services are not prior authorized if they duplicate services the legal guardian is required to provide. After community crisis support has been provided, the provider must complete a crisis resolution plan and submit it to the Department within three business days. The crisis resolution plan shall identify the factors contributing to the crisis and must include a proactive strategy to address these factors in order to minimize future occurrences.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. **Election of Participant-Direction.** *(Select one):*

<input checked="" type="checkbox"/>	The State does not offer opportunity for participant-direction of State plan HCBS.
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Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(What agency or entity conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Frequency of Analysis and Aggregation
Administrative Authority						
The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the program by exercising oversight of the performance of State Plan HCBS functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.	The number and percent of remediation issues identified in the Qualified Improvement Strategy (QIS) performance reports that were followed up on and monitored through QIS reporting.	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation	Quarterly	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly
1915(i) Eligibility						
An evaluation for State Plan Home and Community Based Services (HCBS) is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	Number and percent of SIB-R's completed on all applicants who request HCBS services.	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation	Quarterly	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly

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	Number and Percent of initial applicants that meet the needs-based HCBS eligibility during the assessment process.	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation	Quarterly	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly
The levels of care of enrolled participants are reevaluated at least annually.	Number and percent of participants who received an annual redetermination of State Plan HCBS eligibility within 364 days of their previous eligibility evaluation.	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation	Quarterly	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly
The process and instruments described in the approved State Plan Amendment are applied appropriately and according to the approved description to determine participant State Plan HCBS eligibility.	Number and percent of sampled IAP Level of Care determinations where the needs-based State plan HCBS eligibility criteria was determined appropriately.	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: Representative Sample. Confidence Interval = 95%	The State Medicaid Agency is responsible for data collection/generation	Quarterly	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly
Qualified Providers						
The state verifies that providers initially and continually meet required licensure and/or certification standards including HCBS setting qualities prior to furnishing services.	Number and percent of initial State Plan HCBS providers that meet certification standards	Data Source: Provider Performance Monitoring Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation	Continuously and Ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
	Number and percent of ongoing State Plan HCBS providers who met certification requirements	Data Source: Provider Performance Monitoring Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation	Providers are surveyed when they seek renewal of their certificate. The Department issues certificates that are in effect for a period of no longer than three years	The State Medicaid Agency is responsible for data aggregation and analysis	Annually

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The State monitors non-licensed/non-certified providers to assure adherence to provider standards.	Number and percent of new providers that have an initial provider review within 6 months of providing services to participants.	Data Source: Provider Performance Monitoring Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation .	Continuously and Ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
	Number and percent of State Plan HCBS providers who received an on-site review every two years.	Data Source: Provider Performance Monitoring Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection/generation .	Every two years	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved state plan amendment	Number and percent State Plan HCBS direct care staff that meet state requirements for training.	Data Source: Provider Performance Monitoring Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Providers who are not certified are surveyed every two years. The Department issues certificates for certified providers that are in effect for a period of no longer than three years.	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
	Number and percent of participants who have the opportunity to provide feedback to the Department regarding State Plan HCBS providers.	Data Source: Reports to State Medicaid Agency on delegated Administrative functions Sampling Approach: Representative Sample Confidence Interval = 95%	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
Service Plan						
Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by State Plan HCBS service or through other means.	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).	Data Source: Analyzed collected data Sampling Approach: Representative Sample of adult participants receiving HCBS services. Confidence Interval = 95%	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually

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	Number and percent of service plans that address participants' goals as indicated in the assessment(s).	Data Source: Analyzed collected data Sampling Approach: Representative Sample of adult participants receiving HCBS services. Confidence Interval = 95%	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
	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).	Data Source: Analyzed collected data Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
The state monitors service plan development in accordance with its policies and procedures.	Number and percent of participants reviewed whose service plans had adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s).	Data Source: Analyzed collected data Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
	Number and percent of service plans reviewed that were submitted to the Department prior to the expiration of the current plan of service.	Data Source: Analyzed collected data Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
Service plans are updated or revised at least annually or when warranted by changes in the participant's needs.	Number and percent of service plans that are updated/ revised when warranted by changes in the State Plan HCBS participant's needs/goals.	Data Source: Analyzed collected data Sampling Approach: Representative Sample. Confidence Interval = 95%	The State Medicaid Agency is responsible for data collection.	Annually Every two years	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
		Data Source: Provider Performance Monitoring Sampling Approach: During the survey process, 10% of files are reviewed to ensure plan modifications occur when needed and in a timely manner	The State Medicaid Agency is responsible for data collection.			

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Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan	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.	Data Source: Analyzed collected data Sampling Approach: Representative Sample of adult participants receiving HCBS services. Confidence Interval = 95%	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
		Data Source: Provider Performance Monitoring Sampling Approach: During the survey process, 10% of files are reviewed to ensure services are being delivered that are consistent with the plan.	The State Medicaid Agency is responsible for data collection.	Every two years		
Health and Welfare						
The state, on an on-going basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.	Number and percent of service plans that address potential and real risks and back up plans are in place as needed.	Data Source: Analyzed collected data Sampling Approach: Representative Sample of adult participants receiving HCBS services. Confidence Interval = 95%	The State Medicaid Agency is responsible for data collection.	Annually	The State Medicaid Agency is responsible for data aggregation and analysis	Annually
		Data Source: Provider Performance Monitoring Sampling Approach: During the survey process, 10% of files are reviewed to ensure service plans adequately address the health and welfare of participants	The State Medicaid Agency is responsible for data collection.	Every 2 years		
	Number and percent of complaints reported by participants or others	Data Source: Critical events and incident reports Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Continuously and Ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly and Annually

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	Number and percent of substantiated complaints	Data Source: Critical events and incident reports Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Continuously and Ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly and Annually
	Number and percent of critical incidents related to abuse, neglect and exploitation	Data Source: Critical events and incident reports Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Continuously and Ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly and Annually
	Number and percent of substantiated critical incidents related to abuse, neglect, and exploitation with remediation	Data Source: Critical events and incident reports Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection.	Continuously and Ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly and Annually
		Data Source: Provider Performance Monitoring Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection	Continuously and Ongoing		
	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	Data Source: Reports to State Medicaid Agency on delegate Administrative functions Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection	Quarterly	The State Medicaid Agency is responsible for data aggregation and analysis	Quarterly
Financial Accountability						
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology.	Number and percent of demonstrated State Plan HCBS service provider's fraudulent billing patterns investigated by IDHW and action taken.	Data Source: Critical events and incident reports Sampling Approach: 100% Review	The State Medicaid Agency is responsible for data collection	Continuously and Ongoing	The State Medicaid Agency is responsible for data aggregation and analysis	Annually

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Supplement 2 to Attachment 3.1-A, Program Description

System Improvement: <i>(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)</i>			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
<p>The Division of Medicaid, Bureau of Developmental Disability Services (BDDS) has a Quality Assurance Management Team. This team includes:</p> <ul style="list-style-type: none"> • BDDS Bureau Chief • BDDS Quality Manager • BDDS HUB Managers • BDDS Policy Staff <p>This team is responsible for reviewing Quality Improvement Strategy findings and analysis (including trending), formulating remediation recommendations, and identifying and addressing any statewide resource or program issues identified in QA business processes.</p> <p>Recommended program changes or system improvement processes are then referred to the Central Office Management Team (COMT) for review and approval. The COMT is responsible for reviewing BDDS quality improvement recommendations. The COMT prioritizes recommendations taking into consideration division wide resources, coordination issues and strategies. Based on prioritization, the COMT makes final remediation decisions and implements system wide change.</p> <p>The BDDS Quality Manager is responsible for leading team members and the Quality Assurance tasks for State Plan HCBS services. The Quality Manager is responsible for finalizing quarterly and yearly Quality Management reports, leading the process of prioritizing needs for system improvements, and implementing approved system improvements.</p>	<p>State Medicaid Agency is Responsible for Remediation Data Aggregation and Analysis</p>	<p>Quarterly</p>	<p>When the Central Office Management Team (COMT) identifies system wide changes, The BDDS Quality Assurance Management Team monitors and analyzes the effectiveness of the design change.</p> <p>The BDDS Quality Assurance Team comprised of BDDS Regional Quality Assurance Staff and BDDS Quality Data Analyst are responsible for implementation of quality assurance related activities as defined in the quality improvement strategy</p> <p>All design changes are tracked through a Continuous Quality Improvement task list. This task list identifies:</p> <ul style="list-style-type: none"> • the description of a task • the implementation plan • monitoring plan • outcome <p>Quality improvement tasks are monitored on a quarterly and annual basis and updates are given to the COMT.</p> <p>The Division of Medicaid's BDDS Quality Manager is responsible for the management and oversight of BDDS's QA system. These duties include:</p> <ul style="list-style-type: none"> • implementation and monitoring of quality improvement strategy • training and oversight of the BDDS Quality Assurance Team • related data collection • reporting • continuous quality improvement and remediation processes and activities <p>As part of quarterly monitoring activities, the Quality Manager evaluates the quality improvement strategy for effectiveness and recommends changes as needed.</p>