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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

A. The **State** of **Idaho** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
B. **Program Title:**
Idaho Developmental Disabilities Waiver (renewal)
C. **Waiver Number:ID.0076**
Original Base Waiver Number: ID.0076.90.R3B
D. **Amendment Number:ID.0076.R05.03**
E. **Proposed Effective Date:** *(mm/dd/yy)*
10/01/13
Approved Effective Date of Waiver being Amended: 10/01/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of this amendment is to revise the maximum unduplicated number of waiver participants for waiver years 2-5 (10/01/2013 - 9/30/2017). Additionally, the state has added the monitoring of unduplicated participants to the quarterly evaluation of the Quality Improvement Strategy and updated the goals for participant direction.

For at least one year after the approval of the waiver amendment, the state will report unduplicated participants on a quarterly basis to the state's regional CMS representative.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A – Waiver Administration and Operation**	
☑ **Appendix B – Participant Access and Eligibility**	B-3-a; B-QIS-b-i
☐ **Appendix C – Participant Services**	

Component of the Approved Waiver	Subsection(s)
☐ Appendix D – Participant Centered Service Planning and Delivery	
☑ Appendix E – Participant Direction of Services	E-1-n
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☑ Appendix H	H-1-b
☐ Appendix I – Financial Accountability	
☑ Appendix J – Cost-Neutrality Demonstration	J-1; J-2-a. J-2-d

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

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

Specify:

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Idaho Developmental Disabilities Waiver (renewal)

C. Type of Request:amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: ID.0076
Waiver Number:ID.0076.R05.03
Draft ID: ID.03.05.01

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/12
Approved Effective Date of Waiver being Amended: 10/01/12

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

- ☐ **Hospital**

Select applicable level of care

- ( ) **Hospital as defined in 42 CFR §440.10**
  If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
- ( ) **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

[ ] **Nursing Facility**

Select applicable level of care

- ( ) **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**
  If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
- ( ) **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

[x] **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

- (•) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- [ ] **Waiver(s) authorized under §1915(b) of the Act.**

  Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

  Specify the §1915(b) authorities under which this program operates *(check each that applies):*
  - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
  - [ ] **§1915(b)(2) (central broker)**
  - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
  - [ ] **§1915(b)(4) (selective contracting/limit number of providers)**
- [ ] **A program operated under §1932(a) of the Act.**

  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

  Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:
☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
Idaho makes waiver services available to eligible participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For an adult participant to be eligible the Department must find that the participant requires services due to a developmental disability that impairs his mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/ID.

The Department's contractor determines an individual's developmental disability eligibility and/or ICF/ID Level of Care eligibility for waiver services and assigns an individualized budget. Participants who meet ICF/ID LOC eligibility may choose to receive either traditional waiver services or consumer directed services.

Traditional Services: Participants who select traditional services must use a plan developer to develop a plan of service. The costs for all paid supports identified on the participant's plan of service must not exceed the individualized budget assigned to them for the upcoming plan year. In developing the plan of service, the person must identify services and supports available outside of Medicaid-funded services that can help them meet their desired goals. The plan of service must identify: type of services to be delivered; Goals to be addressed within the plan year; frequency of supports and services; and service providers.

In addition, the plan of service must include activities to promote progress, maintain functional skills, delay or prevent regression, and allow for health and safety.

Participants who select traditional pathway services may elect to receive residential habilitation services through one of two ways: Certified Family Home (home of the provider) or Supported Living Services (home of the participant).

Residential Habilitation—Certified Family Home (CFH): When residential habilitation services are provided in the home of the provider, the direct service provider is not an agency, but rather the CFH is certified by the State. The Department contracts with an outside entity to provide program coordination services as an administrative support to CFHs providing residential habilitation services to participants. Program Coordination services include the development, implementation and monitoring of Program Implementation Plans, initial CFH orientation training and initial/annual participant specific skill building training. The contractor is also responsible for quality assurance and quality improvement activities specifically related to program coordination duties identified in the contract. The program coordinator working with the CFH does not provide direct services to the participant.

Supported Living Residential Habilitation: When residential habilitation services are provided in the home of the participant, residential habilitation services are provided by an agency. The agency must be certified by the Department and must be capable of supervising the direct services provided. All plans of service that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination.

In addition to residential habilitation services, the following traditional Adult DD Waiver services are also available:
Chore Services;
Respite;
Community Supported Employment;
Non-Medical Transportation;
Environmental Accessibility Adaptations;
Specialized Equipment and Supplies;
Personal Emergency Response System;
Home Delivered Meals;
Skilled Nursing;
Dental Services
Behavior Consultation or Crisis Management; and
Adult Day Health.

Participants who select traditional pathway services select from approved Medicaid providers who bill directly through the MMIS system.

Consumer-Directed Services: The consumer directed services option requires the participant to have a support broker to assist the participant to make informed choices, participate in a person-centered planning process, and become skilled at managing his own supports. The participant must use a fiscal employer agent Medicaid provider to provide Financial Management Services (FMS) for payroll and reporting functions. The plan of service must identify:

• The participant's preferences and interests by identifying all the supports and services, both paid and non-paid, the participant wants and needs to live successfully in his community.
• Response to emergencies including access to emergency assistance and care.
• Risks or safety concerns in relation to the identified support needs on the participant's plan. The plan must specify the supports or services needed to address the risks for each issue listed; and
• Sources of payment for the listed supports and services, including the frequency, duration, and main task of the listed supports and services. Support and spending plans that exceed the approved budget amount will not be authorized.
A participant cannot receive traditional services and consumer-directed services at the same time. A CSW may not provide group services to participants receiving traditional and consumer directed services. However, a CSW may provide 1 on 1 services to a participant self-directing services in the same physical setting as traditional participant(s) receiving services from other providers. This limitation does not preclude a participant who has selected the consumer-directed option from choosing to live with recipients of traditional services.

Review and approval of proposed plans of care (traditional or consumer directed services), exception review, and hearings to appeal a Department decision regarding adult DD eligibility, ICF/ID LOC eligibility or service plan denial are handled by the Department.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. **Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. **Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. **Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

   1. Informed of any feasible alternatives under the waiver; and,

   2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. **Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
Idaho has well-established provider, advocate, and participant associations that provide frequent feedback to the Department regarding our programs for people with developmental disabilities, including the DD waiver program. Whenever changes to the waiver are considered by the Department, we solicit input from these associations as well as other potentially affected stakeholders.

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

For this waiver renewal, the Department sought public input on changes to rules to be made in conjunction with the renewal of the Aged and Disabled waiver and the Developmental Disabilities waiver. A negotiated rule making session was held on May 31, 2012 for the purpose of discussing the waiver renewal and potential rule changes to maintain waiver authority and offer waiver benefits.

Additionally, the tribal solicitation was sent to the Tribal Representative on June 5, 2012.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Perry

First Name: Stephanie

Title: Alternative Care Coordinator

Agency: Idaho Division of Medicaid

Address: P.O. Box 83720

Address 2:

City: Boise

State: **Idaho**

Zip: 83720-0036

Phone: (208) 364-1878 **Ext:** ☐ **TTY**

Fax: (208) 332-7286

E-mail: perrys@dhw.idaho.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Idaho**

Zip:

Phone:

Fax: **Ext:** **TTY**

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Rachel Strutton

State Medicaid Director or Designee

Submission Date: Mar 10, 2014

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Strutton

First Name: Rachel

Title: Medicaid Director designee

Agency: Department of Health and Welfare Division of Medicaid

Address: P.O. Box 83720

Address 2:

City: Boise

State: **Idaho**

Zip: 83720-0009

Phone:

Fax: (208) 364-1836 **Ext:** ☐ **TTY**

E-mail: (208) 364-1811

Attachment #1: Transition Plan

Specify the transition plan for the waiver: struttor@dhw.idaho.gov

Idaho is not requesting any modifications which would impact a reduction in participant services requiring a transition.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

DENTAL WAIVER SERVICES

Participants on the Aged and Disabled or Developmental Disability waiver will receive dental services that must include, but are not limited to, exams, diagnostic and preventive services, basic restorations, periodontics, oral surgery, and adjunctive dental services.

Code	Description	Age limitation	Teeth Covered	Auth. Req'd	Benefit Limitation	Documentation Required
D0120	Periodic oral evaluation	21 and older		No	One of (D0120, D0150) per 12 months per patient	
D0140	Limited oral evaluaton-problem focused	21 and older		No	Two of (D0140) per 12 months per patient	
D0150	Comprehensive oral evaluation	21 and older		No	One of (D0150) per 36 months per Provider OR location. One of (D0120,D0150) per 12 months per patient	
D0210	Intraoral-complete series (including bitewings)	21 and older		No	One of (D0210, D0277, D0330) per 36 Months per patient	
D0220	Intraoral-periapical-1st film	21 and older		No		
D0230	Intraoral-periapical-each additional film	21 and older		No		
D0270	Bitewing-single film	21 and older		No	One of (D0270, D0272, D0273, D0274, D0277) per 12 months per patient	
D0272	Bitewing-two films	21 and older		No	One of (D0270, D0272, D0273, D0274, D0277) per 12 months per patient	
D0273	Bitewing-three films	21 and older		No	One of (D0270, D0272, D0273, D0274, D0277) per 12 months per patient	
D0274	Bitewing-four films	21 and older		No	One of (D0270, D0272, D0273, D0274, D0277) per 12 months per patient	
D0277	Vertical bitewings-7-8 films	21 and older		No	One of (D0270, D0272, D0273, D0274, D0277) per 12 months per patient. One of (D0210, D0277, D0330) per 36 months per patient	
D0330	Panoramic Film	21 and older		No	One of (D0210, D0277, D0330) per 36 months per patient	
D0999	Unspecified diagnostic procedure, by report	21 and older		Yes		Narrative of medical necessity

D1110	Prophlaxis-adult				One of (D1110) per 6 months per patient. One of D1110, D1120, D4355, D4910)per 1 day(s) per patient. Allow for one prophylaxis service per participant every 6 months. Includes scaling & polishing procedure to remove coronal plaque, calculus & stains
D1204	Topical application of fluoride	21 and older			One per 12 months
D2140	Amalgam-one surface, primary or permanent	21 and older	Teeth-1-32, A-T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient
D2150	Amalgam-two surfaces, primary or permanent	21 and older	Teeth 1-32, A-T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient
D2160	Amalgam-three surfaces, primary or permanent	21 and older	Teeth 1-32, A-T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient
D2161	Amalgam-four surfaces, primary or permanent	21 and older	Teeth 1-32, A-T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient
D2330	Resin-1, surface, anterior	21 and older	Teeth 6-11, 22-27, C-H, M-R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient
D2331	Resin-2, surfaces, anterior	21 and older	Teeth 6-11, 22-27, C-H, M-R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient
D2332	Resin-3, surfaces, anterior	21 and older	Teeth 6-11, 22-27, C-H, M-R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient
D2335	Resin 4+, surfaces or involving incisal angle (anterior)	21 and older	Teeth 6-11, 22-27, C-H, M-R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient
D2391	Resin-based composite-1 surface, posterior	21 and older	Teeth 1-5, 12-21, 28-32. A,B,1-L,S,T	No	One of (D2391) per 24 months per patient. Reimbursed at amalgam rate
D2392	Resin-based composite-2 surfaces, posterior	21 and older	Teeth 1-5, 12-21, 28-32. A,B,1-L,S,T	No	One of (D2392) per 24 months per patient. Reimbursed at amalgam rate
D2393	Resin-based composite-3 surfaces, posterior	21 and older	Teeth 1-5, 12-21, 28-32. A,B,1-L,S,T	No	One of (D2393) per 24 months per patient. Reimbursed at amalgam rate
D2394	Resin-based composite-4 or more surfaces, posterior	21 and older	Teeth 1-5, 12-21, 28-32. A,B,1-L,S,T	No	One of (D2394) per 24 months per patient. Reimbursed at amalgam rate
D2920	Recement Crown	21 and older	Teeth 1-32 A-T	No	Not covered within 6 months of initial placement
D2940	Sedative filling	21 and older	Teeth 1-32	No	Temporary restoration intended to

A-T relive pain. Not to be used as a base or liner under a restoration. Cannot be used as interim restoration with any code D3220-D3430

D2330 Therapeutic pulpotmy (excluding final restoration 21 and older Teeth 1-32 A-T No One of (D3220, D3221)per 1 lifetime per patient

D3221 Gross pulpal debridement primary and permanent teeth 21 and older Teeth 1-32 A-T No One of (D3220, D3221)per 1 lifetime per patient

D4341 Peridontal scaling and root planning, per quadrant 21 and older Per quadrant (10, 20, 30, 40, LL, LR, UL, UR) Yes One of (D4341, D4342) per 24 months per patient. A minimum of four (4) affected teeth in the quadrant. There must be a significant root calculus or noticeable loss of bone support Pre-op x-ray(s), perio charting

D4342 Periodontal scaling and root planning, 1-3 teeth per quadrant 21 and older Per quadrant (10, 20, 30, 40, LL, LR, UL, UR) Yes One of (D4341, D4342) per 24 months per patient. A minimum of four (4) affected teeth in the quadrant. There must be a significant root calculus or noticeable loss of bone support Pre-op x-ray(s), perio charting

D4355 Full mouth debridement to enable comprehensive periodontal evaluation 21 and older Yes One of (D4355) per 1 lifetime per patient. One of (D1110, D1120, D4355, D4910) per 1 day(s) per patient Pre-operative x-ray(s)

D4910 Periodontal maintenance procedures 21 and older Yes Two of (D4910) per 12 months per patient. One of (D1110, D1120, D4355, D4910) per 1 day(s) per patient. Not covered within 90 days of active treatment Dates of active therapy

Prosthodontics, removable

D5110 Complete denture-maxillary 21 and older Yes One of (D5110, D5130, D5211, D5213) per 84 months per patient, Photographs are acceptable in lieu of x-rays for dentures Pre-operative x-rays(s)

D5120 Complete denture-mandibular 21 and older Yes One of (D5120, D5140, D5212, D5214) per 84 months per patient, Photographs are acceptable in lieu of x-rays for dentures Pre-operative x-rays(s)

D5130 Immediate denture-maxillary 21 and older Yes One of (D5110, D5130, D5211, D5213) per 84 months per patient Narrative of medical necessity, pre-operative x-rays(s)

D5140 Immediate denture-mandibular 21 and older Yes One of (D5120, D5140, D5212, D5214) per 84 months per patient Narrative of Medical necessity, Pre-operative x-ray(s)

D5211 Maxillary partial denture-resin base 21 and older Yes One of (D5110, D5130, D5211, D5213) per 84 months per patient Pre-operative x-ray(s)

D5212 Mandibular partial denture-resin base 21 and older Yes One of (D5120, D5140, D5212, D5214) per 84 months per patient Pre-operative x-ray(s)

D5410 Adjust complete denture-maxillary 21 and older No One of (D5410) per 12 months per patient, not covered within 6 months of placement

D5411 Adjust complete denture-mandibular 21 and older No One of (D5411) per 12 months per patient, not covered within 6 months of placement

D5421 Adjust partial denture-maxillary 21 and older No One of (D5421) per 12 months per patient, not covered within 6 months of placement

D5422 Adjust partial denture-mandibular 21 and older No One of (D5422) per 12 months per patient, not covered within 6 months of placement

D5510 Repair broken complete 21 and older Per arch No One of (D5510) per 12 months per patient

	denture base	(01,02, LA,UA)				
Oral and Maxillofacial Surgery						
D7111	Coronal remnants-erupted or exposed root	21 and older	Teeth A-T, AS,BS,CS, DS,ES,FS, GS,HS,IS, JS,KS,LS, MS,NS,OS, PS,QS,RS, SS,TS	No		
D7140	Extraction-erupted or exposed root	21 and older	Teeth 1-32,51-82 A-T,AS, BS,CS,DS, ES,FS,GS, HS,IS,JS, KS,LS,MS, NS,OS,PS, QS,RS,SS, TS	No		
D7210	Surgical removal erupted tooth requiring elevation of mucoperiosteal flap	21 and older	Teeth 1-32,51-82	Yes	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure	Narrative of medical necessity, pre-op x-ray(s)
D7210	Surgical removal erupted tooth requiring elevation of mucoperiosteal flap	21 and older	Teeth A-T AS,BS,CS, DS,ES,FS, GS,HS,IS, JS,KS,LS, MS,NS,OS, PS,QS,RS, SS,TS	No	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure	
D7220	Removal of impacted tooth-soft tissue	21 and older	Teeth 1-32,51-82 A-T,AS, BS,CS,DS, ES,FS,GS, HS,IS,JS, KS,LS,MS, NS,OS,PS, QS,RS,SS, TS	Yes	Removal of asymptomatic tooth not covered	Narrative of medical necessity, pre-op x-ray(s)
D7230	Removal of impacted tooth-partially bony	21 and older	Teeth 1-32,51-82 A-T,AS, BS,CS,DS, ES,FS,GS, HS,IS,JS, KS,LS,MS, NS,OS,PS, QS,RS,SS, TS	Yes	Removal of asymptomatic tooth not covered	Narrative of medical necessity pre-op x-ray(s)
D7240	Removal of impacted tooth-completely bony	21 and older	Teeth 1-32,51-82 A-T,AS, BS,CS,DS,	Yes	Removal of asymptomatic tooth not covered	Narrative of medical necessity, pre-op x-ray(s)

		ES,FS,GS, HS,IS,JS, KS,LS,MS, NS,OS,PS, QS,RS,SS, TS				
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1-32,51-82 A-T,AS, BS,CS,DS, ES,FS,GS, HS,IS,JS, KS,LS,MS, NS,OS,PS, QS,RS,SS, TS	Yes	Unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required, aberrant tooth position, or unusual depth of impaction	Narrative of medical necessity, pre-op x-ray(s)
D7250	Surgical removal of residual tooth roots	21 and older	Teeth 1-32,51-82 A-T,AS, BS,CS,DS, ES,FS,GS, HS,IS,JS, KS,LS,MS, NS,OS,PS, QS,RS,SS, TS	Yes	Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	Narrative of medical necessity, pre-op x-ray(s)
D7286	Biopsy of oral tissue-soft (all others)	21 and older		Yes		Pathology report
D7510	Incision and drainage of abscess-intraoral soft tissue	21 and older	Teeth 1-32,51-82 A-T,AS, BS,CS,DS, ES,FS,GS, HS,IS,JS, KS,LS,MS, NS,OS,PS, QS,RS,SS, TS	No	One of (D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 day(s) per patient	
D7970	Excision of hyperplastic tissue-per arch	21 and older	Per arch (01,02, LA,US)	No		
Adjunctive General Services						
D9110	Palliative (emergency) treatment of dental pain minor procedure	21 and older		No	Not allowed with any other services other than radiographs	
D9220	General anesthesia-first 30 minutes	21 and older		Yes	Maximum of one hour (D9220, D9221)	Narrative of medical necessity
D9221	General anesthesia-each add'l 15 minutes	21 and older		Yes	Two of (D9221) per 1 day(s) per patient. Max of 2 units	Narrative of medical necessity
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	21 and older		Yes	Not allowed with D9220, D9221, D9241, D9242 or D9248	Narrative of medical necessity
D9241	Intravenous sedation/ analgesia- first 30 minutes	21 and older		Yes	Maximum of one hour (D9241, D9242)	Narrative of medical necessity
D9242	Intravenous sedation/ analgesia-each add'l 15 minutes	21 and older		Yes	Maximum of 2 units	Narrative of medical necessity
D9248	Non-intravenous conscious sedation	21 and older		No	Must be documented as medically necessary in the patient record. Not allowed with D9220, D9221, D9230, D9241 or D9242. Qualifying permit must be held by the treating	

				provider
D9310	Consultation	21 and older	No	Two of (D9310) per 12 months per patient. One of (D9310) per 1 lifetime per provider OR location. Not allowed by treating provider
D9410	House/Extended Care call	21 and older		
D9420	Hospital Call	21 and older		
D9920	Behavior Management	21 and older		

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:
   Bureau of Developmental Disability Services
   (Do not complete item A-2)

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   (Complete item A-2-a).

   ○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
  The Department contracts with an Independent Assessment Provider (IAP) to complete level of care determinations and assign individualized budgets.

  The Department contracts with a Program Coordination Provider who provides administrative services on behalf of the Department for the oversight, quality assurance and improvement, and program coordination of the residential habilitation programming provided by the Certified Family Home provider.

  The Department contracts with Blue Cross Idaho who subcontracts with Dentaquest for a dental insurance program called Idaho Smiles. Idaho Smiles/Dentaquest is responsible for management of dental services.
- ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- (●) **Not applicable**
- ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
  - [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

    Specify the nature of these agencies and complete items A-5 and A-6:
  - [ ] **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

    Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Idaho Division of Medicaid is responsible for assessing the performance of the Independent Assessment Provider contract, the Residential Habilitation Program Coordination contract and the Idaho Smiles dental contract.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
IAP contract monitoring:
1.Monthly (IAP) data and review: Data is collected that reflects the IAP's performance according to the defined business model timeframes. When performance measures are not met, or there are changes in performance expectations, program managers from the DD Bureau and the IAP contractor discuss the issues and identify changes as needed to get back on track. The Department has ongoing reviews data on a monthly basis.

2.Quarterly contract monitoring reports: This report looks at each performance standard and provides information in relation to compliance. If the performance was not satisfactory, follow-up is completed by the DD Bureau contract monitor to develop a plan of correction specific to the problem area.

3.IAP performance review: This process looks at the IAP files. The goal is to establish that regional IAP offices are consistent with the statewide business model. The areas reviewed are: documents are tracked and accessible; necessary signatures are obtained; documents are processed within business model timeframes; accurate documentation related to participant diagnosis, medical history and medical or behavioral needs are recorded, level of care eligibility correctly determined according to the Idaho standard, demographic information is correctly recorded.

4.Outcome-Based Review: The intent of the outcome-based review is to ensure that the components of the business model are being implemented consistently across the state to ensure participants are receiving services to meet their needs.

One or both of the IAP performance reviews are completed on an annual basis. The information received through these review processes validate the performance of the IAP in relation to clinical decision making. This information is provided to the IAP. A plan of correction must be developed for those areas not meeting contract performance standards.

Residential Habilitation Contract Monitoring:
1. Initial/Annual Program Implementation Plan Completion Timeframes: The Contractor completes CFH orientation, CFH skill building, and submits participant PIPs to the CFH provider within timeframes.
The contractor will complete a quarterly database review of activities related to CFH training and/or development and implementation of PIPs within timeframes. The quarterly report will include those participants whose initial/annual plan was implemented during the quarter being reported on.

2. Initial/Annual Program Implementation Plan Performance: PIP objectives and skill building instructions completed by Contractor accurately reflect participant goals identified in the participant's plan of service. The contractor will complete a monthly review of information entered into its database related to participant Program Implementation Plan (PIP) performance. The contractor will complete a review of participant files to identify if PIP objectives and skill building instructions accurately reflect participant goals identified in the plan of service/addendum(s) approved for participant. Number of participant files reviewed each quarter will be based on an annual sample size identified by the Department. This sample size is based on the total number of participants projected to be served by the contractor in a given contract year and is calculated with a 5% margin of error and a 95% confidence level.

3. Program Coordinator Qualifications: The Contractor utilizes staff that meets the qualification required through the program coordination contract. The contractor will review employee files to verify credentials, resumes and job qualifications meet requirements. Contractor will develop a quarterly report which reports the results of employee file review.

4. Database: The Contractor will maintain a current and accurate database with sorting capabilities. The Department will review data submitted through reports/spreadsheets and periodic review of contractor database. The contractor will develop a quarterly report which summarizes its progress and efforts related to fulfilling contract requirements, to include database capabilities.

5. Participant /CFH Residential Habilitation Satisfaction Survey: The Contractor shall annually assess the participants' and Certified Family Homes' satisfaction related to program coordination services received.
The contractor will develop an annual report which includes the number of participants and CFHs served, summary results of overall participant and CFH provider satisfaction with program coordination services received, and any changes to the Contractor's business processes as a result of findings identified through the survey. The contractor will develop and submit a monthly Complaint Data report to the Department. This report identifies any complaints received by contractor regarding Program Coordination service provision.

6. Health and Safety Reporting: The Contractor shall report concerns related to participant health and safety directly to the Department and as mandatory reporters, to authorities (as applicable). The documentation will identify date the concern was discovered or reported to the Contractor, the date the concern was submitted to the Department and authorities (as applicable), and the nature of the concern. The contractor will develop and submit a monthly Health and Safety data report to the Department. This report will identify concerns related to participant health and safety. The contractor will develop and submit a Monthly Certified Family Home Provider Implementation Issues report to the Department. This monthly report will identify any issues identified in the prior month that impact the implementation of program coordination services for a participant where Department intervention is required.

7.Reconciled Billing: The Contractor shall submit monthly invoices for services provided within the Scope of Work. The contractor will develop and submit a monthly invoice for services provided.

Required Level of Expectation for the above performance metrics is 100% with the exception of Initial/Annual Program Implementation Plan Performance which is at 95%. Failure to resolve an identified performance issue may require the Department to impose remedies.

Dental contract monitoring:
1. Administration and operation of the Dental Plan: The Contractor must process claims accurately and within a timely manner; 95% of clean claims will be processed within 30 days of receipt.
Method of Monitoring: IDHW's eligibility files, Contractor's reports, input from providers and participants, on-site monitoring visits, and ongoing communication and consultation with the Contractor.

2. Statewide Dental Provider Network: The Contractor shall maintain a statewide network of dental providers that includes FQHCs, and must enroll a sufficient number of dental providers to ensure that at least 90% of participants have a provider within 30 miles of their residence in Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock, and Bonneville counties, and within 60 miles of their residence in all other counties. The statewide network of dental providers shall be available within 120 days of the contract effective date, and be maintained throughout the entire contract period.
Method of Monitoring: Review of utilization and claims reports from the Contractor, input and complaints against dental providers received by the IDHW and the Contractor, on-site monitoring visits, Board of Dentistry information, state and federal sanction lists, and ongoing communications and consultation with the Contractor.

3. Availability of Service: The Contractor has a system of accountability and ensures participants have timely access to the dental services included in the contract. The Contractor shall not exceed the timeframes established to provide reasonable access to care.
a. Waiting time for an appointment for periodic dental evaluations or prophylactic care (cleanings, fluoride varnish, sealants):45 calendar days
b. Wait time for an appointment for non-urgent, problem focused dental appointments: 7 calendar days
c. Wait time for an appointment for urgent dental appointments for treatment of specific problem requiring immediate attention: 24 hours (routine referral to the local emergency room is not acceptable)
d. Time allowed for the Contractor to find a provider, in or out of network, who will agree to treat a participant if a participant cannot find a provider on their own: 7 calendar days for non-urgent cases and 2 business days for urgent cases

Method of Monitoring: Review of the monthly reports, feedback from providers and participants, on-site monitoring. The IDHW may perform random testing of the system of accountability as part of a quality assurance process.

4. Complaint and Grievance Tracking Systems: The Contractor maintains tracking systems to document complaints and grievances received, ensures the resolutions for each are documented in the tracking system and provides the information to the IDHW.
Method of Monitoring: Review of the monthly Provider and Participant Complaint and Grievance logs, calls and emails to IDHW from providers and participants, ongoing communication and consultation with the Contractor.

Required Level of Expectation for the above performance metrics is 100%. Failure to resolve an identified performance issue may require the Department to impose remedies. The dental contract monitor reviews utilization, billing and complaint/grievance reports on a monthly basis. Each quarter, the contract monitor analyzes the contractor's execution of the contract based on the performance metrics.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☑
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☐
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☐
Prior authorization of waiver services	☑	☐
Utilization management	☑	☐
Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☐
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of remediation issues identified in the QIS performance reports that were followed up on and monitored through QIS reporting. a.Numerator: number of remediation issues followed up on and monitored through QIS reporting b.Denominator: number of remediation issues identified in the QIS performance reports

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Medicaid BDDS Quality Manager is responsible for QA remediation and system improvement processes and reporting.

The Division of Medicaid BDDS Quality Assurance Team is responsible for identifying and addressing any statewide resource or program issues identified in QA business processes. Reports are analyzed and the result of the analysis is reported to the BDDS Quality Manager. Recommended program changes or system improvement processes are sent to the Medicaid Quality Management Oversight Committee for approval.

The Division of Medicaid Bureau of Developmental Disability Services Quality Oversight Committee, (comprised of Quality Manager, BDDS Data Analyst, Quality Team representatives, BDDS Care Manager representatives, BDDS Policy Staff) is responsible for review of data and Annual BDDS LOC Report findings, identification of remediation activities, and monitor of ongoing system improvement initiatives and activities. Recommendations are submitted to BDDS Bureau Chief for consideration.

The Division of Medicaid BDDS Management Team is responsible for identifying and addressing any statewide resource or program issues identified in QA business processes. Reports are analyzed and the result of the analysis is reported to the BDDS Bureau Chief. Recommended program changes or system improvement processes are sent to the Central Office Management Team (COMT)for approval.

Medicaid's Central Office Management Team (COMT)is responsible for reviewing BDDS and other Medicaid program report analyses and recommendations, considering Division wide resources and coordination issues and strategies and making final system wide change decisions

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

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

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☑ **Intellectual Disability or Developmental Disability, or Both**					
	☑	**Autism**	18		☑

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☑	Developmental Disability	18		☑
	☑	Intellectual Disability	18		☑
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- (●) **Not applicable. There is no maximum age limit**
- ( ) **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- [ ] **The participant is referred to another waiver that can accommodate the individual's needs.**
- [ ] **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	3196
Year 2	3709
Year 3	3935
Year 4	4159
Year 5	4371

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

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

Entry to the waiver is offered to individuals based on the date they are determined eligible for waiver services. Entrants to the waiver must:
• Be age 18 or older
• Meet ICF/ID level of care
• Have income at or less than 300% of SSI Federal Benefit Rate

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ( ) **§1634 State**
   - (●) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ○ **No**
   - ◉ **Yes**

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☑ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ○ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

    Specify percentage:
- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

  Select one and complete Appendix B-5.

  - ○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
  - ◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

    Check each that applies:

☑ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**
○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- **The following standard included under the State plan**

  Select one:

  - **SSI standard**
  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The special income level for institutionalized persons**

    (*select one*):

    - **300% of the SSI Federal Benefit Rate (FBR)**
    - **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - **A percentage of the Federal poverty level**

    Specify percentage:
  - **Other standard included under the State Plan**

    Specify:
- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The following formula is used to determine the needs allowance:**

  Specify:

  300% of SSI single rate plus the following personal needs allowances if there is enough income.

  Persons with earned income. The personal needs allowance is increased by $200 or the amount of their earned income, whichever is less. These individuals need a greater personal needs allowance to offset their costs incurred in earning income.

  Persons with taxes mandatorily withheld from unearned income for income tax purposes before the individual receives the income. These individuals need a greater personal needs allowance to offset their mandatory income taxes.

Persons with a court-ordered guardian. The personal needs allowance is increased by guardianship fees not to exceed 10% of the monthly benefit handled by the guardian, or $25, whichever is less. Where the guardian and the trustee are the same individual, the total deduction for guardian and trust fees must not exceed $25. These individuals need a greater personal needs allowance to offset their guardian fees.

Persons with a trust. The personal needs allowance is increased by trust fees, not to exceed $25 paid to the trustee for administering the individual's trust. These individuals need a greater personal needs allowance to offset their trust fees.

Blind or disabled employed persons with impairment-related work expenses. Impairment-related work expenses are purchased or rented items and services purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment related items is deducted. Expenses must not be averaged. These individuals need a greater personal needs allowance to offset their impairment-related work expenses.

Income garnished for child support. Any child support payments withheld from earned or unearned income due to a court order are considered "income garnished for child support". Income garnished for child support if not already deductible from income under 42 CFR 435.726(c)(3) for children living in the individual's home with no community spouse living in the home.

○ **Other**

Specify:

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

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional State supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**

◉ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

The State does not establish reasonable limits.

The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

  Specify percentage:

- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised

- **The following formula is used to determine the needs allowance:**

  Specify formula:

  300% of the SSI Federal Benefit Rate plus the following personal needs allowances if there is enough income.

  Persons with earned income. The personal needs allowance is increased by $200 or the amount of their earned income, whichever is less. These individuals need a greater personal needs allowance to offset their costs incurred in earning income.

  Persons with taxes mandatorily withheld from unearned income, whichever is less. These individuals need a greater personal needs allowance to offset their costs incurred in earning income.

  Persons with taxes mandatorily withheld from unearned income for income tax purposes before the individual receives the income. These individuals need a greater personal needs allowance to offset their mandatory income taxes.

  Persons with a court-ordered guardian. The personal needs allowance is increased by guardianship fees not to exceed 10% of the monthly benefit handled by the guardian, or $25, whichever is less. Where the guardian and the trustee are the same individual, the total deduction for guardian and trust fees must not exceed $25. These individuals need a greater personal needs allowance to offset their guardian fees.

  Persons with a trust. The personal needs allowance is increased by trust fees, not to exceed $25 paid to the trustee for administering the individual's trust. These individuals need a greater personal needs allowance to offset their trust fees.

  Blind or disabled employed persons with impairment-related work expenses. Impairment-related work expenses are purchased or rented items and services purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment related items is deducted. Expenses must not be averaged. These individuals need a greater personal needs allowance to offset their impairment-related work expenses.

  Income garnished for child support. Any child support payments withheld from earned or unearned income due to a court order are considered "income garnished for child support". Income garnished for child support if not already deductible from income under 42 CFR 435.726(c)(3) for children living in the individual's home with no community spouse living in the home.

- **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR

§435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ( ) **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- (●) **The State does not establish reasonable limits.**
- ( ) **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**

By an entity under contract with the Medicaid agency.

Specify the entity:

Idaho Center for Disability Evaluation

Other

Specify:

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Independent Assessment Providers who perform the initial evaluation of level of care must be a Qualified Mental Retardation Professional who meets the qualifications specified in the Code of Federal Regulations, Title 42 section 483.430.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Participants must meet ICF/ID level of care as defined in IDAPA 16.03.10.584. Criteria described in this section of rule is listed below.

1. 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 16.13.10; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition.

2. Active Treatment. Persons living in an ICF/ID, must require and receive intensive inpatient active treatment as defined in Section 010 of these rules, to advance or maintain his functional level.

3. 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.

In addition to the above criteria, an individual must demonstrate one of the following:
A. Functional Limitations. Persons (sixteen (16) years of age or older) 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 a full scale functional assessment (Woodcock Johnson Scales of Independent Behavior, or SIB-R, or subsequent revisions) would qualify.

B. Maladaptive Behavior
• 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
• 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.

C. Combination 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 and it can been determined they are in need of the level of services provided in an ICF/ID, including active treatment services. Significance would be defined as:
• 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.

D. Medical Condition. Individuals may meet ICF/ID level of care based 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.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The initial Eligibility Application for Adults with Developmental Disabilities is submitted to the Bureau of Developmental Disability Services (BDDS) in the region in which the participant seeking services resides.

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 ICF/ID Level of Care (LOC) criteria.

ICDE is responsible for completing the ICF/ID LOC 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 participant in completing the following assessments: 1) 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 ICF/ID LOC criteria as follows:

i.Developmental Disability diagnosis. ICDE obtains evaluations and other information needed to verify the participant has a primary diagnosis of being intellectually disabled. A developmental disability means a chronic disability of a person which appears before the age of 22 (twenty-two) years and is attributable to an impairment such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one of these impairments and requires treatment or services. Participants must provide ICDE with the results of psychometric testing if eligibility for developmental disabilities services is based on an intellectual disability and they have no prior testing or prior testing is inconclusive. Documentation of diagnosis is required for participants whose eligibility is based on developmental disabilities other than an intellectual disability.

ii. Functional, Maladaptive or Medical Limitations. ICDE administers a SIB-R to verify the participant's developmental disability results in substantial functional impairment in three or more of seven areas of major life activity and meets ICF/ID LOC criteria based on level of functioning, maladaptive behavior or a combination of functioning and maladaptive behavior. (IDAPA 16.03.10.584.05-07). For individuals who meet ICF/ID LOC based on medical criteria (IDAPA 16.03.10.584.08) the Department's contractor will coordinate with a Nurse Reviewer within the Bureau of Long-term Care, Division of Medicaid, to complete a Supplemental Medical Assessment for ICF/ID Level of Care Determinations, in addition to completing the SIB-R. The Supplemental Medical Assessment is completed to determine whether or not a medical condition has/will significantly affect the functional level/capabilities of a developmentally disabled individual who otherwise may not meet ICF/ID LOC. ICDE must maintain supportive documentation with the Supplemental Medicaid Assessment. A medical condition, for the

purposes of the Supplemental Medicaid Assessment, refers to any chronic or recurrent medical condition, which requires continued medical treatment or follow-up and has a significant impact on the individual's functioning.
iii. Must Require Certain Level of Care. ICDE completes a Medical, Social, Developmental Assessment Summary to validate the participant requires 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.

d. At the time of the face-to-face meeting, ICDE completes an Inventory of Individual Needs with the respondent. This assessment is used to calculate an annual 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 Notices and documentation used to support approval of eligibility into the Member's case file in the Department's MMIS system.

PROCESS FOR ANNUAL LEVEL OF CARE EVALUATION/REEVALUATION

Except for the following differences, the annual eligibility re-determination process is the same:
A new Eligibility Application for Adults with Developmental Disabilities does not have to be submitted by 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 also 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 when it is determined the existing SIB-R does not accurately describe the current status of the participant. ICDE will make a clinical decision about the need for completing a new SIB-R through a review of participant documentation and information provided by respondent during the annual face-to-face eligibility re-determination meeting. However, if a participant's SIB-R scores in the prior year were considered to be 'borderline', ICDE must complete a new SIB-R as part of the annual eligibility determination process. 'Borderline' criteria is as follows:
i. If the person met ICF/ID LOC based on functional criteria, a new SIB-R will be done if the participant's age equivalency is between ages 6.5 and 8 years; OR
ii.If the person met ICF/ID LOC eligibility based on Maladaptive Behavior Criteria, a new SIB-R will be done if the participant's General Maladaptive Index score falls between -22 and -25. OR
iii.If the person met eligibility based on a combination of age equivalency and maladaptive score, a new SIB-R must be completed annually.

ICDE is only required to update those sections of the Medical, Social, Developmental Assessment Summary when the respondent indicates a change has occurred.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

The independent assessment provider (IAP) utilizes an electronic database to track annual redetermination dates and ensures timely reevaluations. The Department ensures the IAP continues to meet contract requirements through monitoring of quarterly IAP reports and annual statewide reviews.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The contractor is required to maintain all participant records for five years after the participant's most recent assessment.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**
   i. **Sub-Assurances:**

      a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

      Performance Measures

      For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

      For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

      Performance Measure:
      Number and percent of SIB-R's completed on all applicants who request HCBS services a.Numerator: Number of SIB-R's completed b.Denominator: Number of applicants who requested HCBS services

      Data Source (Select one):
      Reports to State Medicaid Agency on delegated Administrative functions
      If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percent of initial applicants that meet ICF/ID LOC during the assessment process. a. Numerator: Number of initial applicants that meet ICF/ID LOC b. Denominator: Number of initial applicants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants who received an annual redetermination of eligibility within 364 days of their previous LOC evaluation. a. Numerator: Number of waiver participants who received an annual redetermination within 364 days of their previous LOC evaluation b. Denominator: Number of waiver participants who received an annual redetermination

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of sampled IAP Level of Care determinations where Level of Care was determined appropriately. a.Numerator: Number of sampled determinations where LOC was determined appropriately b.Denominator: Number of sampled IAP level of Care determinations (based on 95% confidence interval)

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Medicaid BDDS Quality Manager is responsible for QA remediation and system improvement processes and reporting.

The Division of Medicaid BDDS Quality Assurance Team is responsible for identifying and addressing any statewide resource or program issues identified in QA business processes. Reports are analyzed and the result of the analysis is reported to the BDDS Quality Manager. Recommended program changes or system improvement processes are sent to the Medicaid Quality Management Oversight Committee for approval.

The Division of Medicaid's Bureau of Developmental Disability Services Quality Oversight Committee, (comprised of Quality Manager, BDDS Data Analyst, Quality Team representatives, BDDS Care Manager representatives, BDDS Policy Staff) is responsible for review of data and Annual BDDS LOC Report findings, identification of remediation activities, and monitor of ongoing system improvement initiatives and activities. Recommendations are submitted to BDDS Bureau Chief for consideration.

The Division of Medicaid's BDDS Management Team is responsible for identifying and addressing any statewide resource or program issues identified in QA business processes. Reports are analyzed and the result of the analysis is reported to the BDDS Bureau Chief. Recommended program changes or system improvement processes are sent to the Central Office Management Team (COMT) for approval.

Medicaid's Central Office Management Team (COMT)is responsible for reviewing BDDS and other Medicaid program report analyses and recommendations, considering Division wide resources and coordination issues and strategies and making final system wide change decisions.

With respect to the waiver amendment submitted in March, 2014, the state assures that it has identified and corrected the system issue regarding the calculation of unduplicated participant counts. For at least one year after the approval of the waiver amendment, the state will report unduplicated participants on a quarterly basis to the state's regional CMS representative. These quarterly reports will include:
• a description of the process used to determine unduplicated participant count
• how the state will monitor and manage waiver capacity
• sufficient data which demonstrates the current number of waiver participants
• sufficient data which demonstrates the number of waiver participants does not exceed what is approved in the waiver
• a detailed description of any identified discrepancies and remediation steps taken.

If the state identifies an increase in capacity that exceeds the unduplicated count, the state will submit a waiver amendment within the waiver year.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

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

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Individuals who inquire about adult DD services are sent an application packet by the Bureau of Developmental Disability Services (BDDS). Each adult Developmental Disability (DD) Services application packet includes a hand -out that identifies all adult DD services available. This handout specifies which services are available to persons who are determined DD eligible and which services are available to persons who meet ICF/ID Level of Care (placement in ICF/ID or HCBS DD waiver services). The Eligibility Application for Adults with Developmental Disabilities included in the application packet also allows a person to choose which services they are seeking from a list. This list includes: DD Waiver Services (traditional or self-directed community supports), Developmental Disability Agency services, ICF/ID, Family Support, Service Coordination, or Other. In addition, information on all adult DD services is included on the public Health and Welfare website, Adult Developmental Disabilities Care Management webpage, Medicaid Services and Supports for Adults with a Developmental Disability.

In addition, participants who choose to access traditional DD and/or HCBS waiver services in lieu of placement in an ICF/ID must develop an individual service plan that identifies the DD services they wish to receive. The signature page of the individual service plan includes a statement for the participant and their legal guardian (as applicable) to initial to indicate they understand the participant has a choice between DD services and placement in an ICF/ID. This statement reads as follows: I have been informed of and understand my choice of waiver

services. I choose to receive waiver services rather than placement in an ICF/ID. I understand that I may, at any time, choose facility admission. A plan cannot be reviewed and approved unless the participant/guardian has initialed this statement.

Participants who choose to access consumer-directed services under the DD Waiver in lieu of placement in an ICF/ID must develop a support and spending plan that identifies the type of consumer directed supports they wish to receive. The support and spending plan includes a page titled Choice and Informed Consent Statements for the participant and their legal guardian (as applicable) to sign to indicate they understand the participant has a choice between consumer directed services and placement in an ICF/ID. This statement reads as follows: I have been informed of and understand my choice of waiver services. I choose to receive waiver services rather than to accept placement in an Intermediate Care Facility for Intellectually Disabled. I understand that I may at any time, choose facility admission. A plan cannot be reviewed and approved unless the participant/guardian has signed this statement.

For participants accessing traditional services, the service coordinator is responsible for answering questions or assisting individuals with information about alternatives and services. Support brokers are responsible for assisting participants with information about alternatives and services for participants accessing consumer-directed services. Department Care Managers are also available to assist participants with questions related to alternatives and services.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Per 45 CFR §92.42, copies of individual service plans and support and spending plans indicating the participant's freedom of choice are maintained and electronically retrievable for a minimum of three (3) years through a Department database (MMIS), as well as a separate database maintained by a Department contractor (ICDE database).

Additionally, a copy of the individual service plan must be retained by the service provider responsible for its development. The requirement for record retention and the length of time these records must be retained is specified in the following rules:
• IDAPA 16.03.10.040.05. Records must be retained by the provider for a period of five (5) years from the date of the final payment under the provider agreement. Failure to retain records for the required period can void the Department's obligation to make payment for the goods or services.
• IDAPA 16.03.10.704.04. When a participant leaves the waiver services program, the records will be retained by the Department as part of the participant's closed case record. Provider agencies will be responsible to retain their participant's records for five (5) years following the date of service.

Also, for participants accessing traditional waiver services, IDAPA 16.03.10.728.03.m. requires the plan developer/service coordination agency to maintain records that document the participant has been informed of the purposes of service coordination, his rights to refuse service coordination, and his right to choose his service coordinator and other service providers'. Per IDAPA 16.03.10.040.05 and IDAPA 16.03.10.704.04, this informed consent documentation would need to be maintained for a minimum of five (5) years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
It is the Department's goal to ensure persons with limited English skills can effectively access its health and human services. More specifically, the Department provides effective communications with clients who have Limited English Proficiency (LEP), are deaf/hard of hearing or are blind and to ensure interpreter services are provided to these clients on a need type basis at no cost to them.

The Directory of Communication Resources lists sources available to help staff obtain the assistance needed when communicating with persons who are limited in their communication ability. The External Resources Section of the Directory can also help staff locate communication assistance. Listed in this section are brief overviews of the Over-the-Phone Interpretation Services, the Idaho Relay Service, and other organizations. The Civil Rights Manager is also available to provide assistance in obtaining services. This Directory is offered simply as a communication aid. Staff are encourages to

refer to the Department's Procedure for Obtaining Interpreter and Translation Services. If staff have a question about this procedure, they are to ask their immediate supervisor. If staff require further assistance, they may contact the Department's Civil Rights Manager.

Interpreter sources include:
a.Foreign Languages
Department of Health and Welfare Employees
Department employees identified as having bilingual skills are listed in the Directory of Interpreter/Communication Resources. Staff contact their organizational unit's Human Resource Specialist to identify those individuals associated with a designated bilingual position.
Over-the-Phone Interpretation Services. Provides over-the-phone interpretation 24 hours a day, 7 days a week. This service should be used with discretion and limited to short conversations generally associated with the gathering and dissemination of initial information and possibly the resolution of immediate problems. The telephone conversations should be done in a private location such as an office or interview room and the conversations should be conducted with the use of a speakerphone, if possible.
On-Call Individual and/or Contract Interpreters
Staff initially utilize the employees listed as internal interpreters in the Department's Directory of Interpreter/Communication Resources. If none are available, staff work with their supervisor to contact one of the On-Call Individual and/or Contract Interpreters in their area.
Other
If appropriate interpreters cannot be identified by using the sources listed in this procedure, please contact your organizational unit's Human Resource Specialist or the Department's Civil Rights Manager at (208) 334-5617, for further assistance.

b.Braille
Idaho Commission for the Blind and Visually Impaired, 341 W. Washington, P.O. Box 83720, Boise, ID 83720-0012, or 1-800-542-8688.

c.Sign Language
Network Interpreting Service (NIS) - schedule sign language interpreters for a fee(1-800-284-1043). To identify the local sign language interpreting services available in the area, refer to Regional Off-Site Resources in the Department's Directory of Interpreter/Communication Resources.

The Department's Division of Health and Welfare's Web page, http://www.healthandwelfare.idaho.gov/ is available for Spanish speaking consumers. A spanish version of Idaho's Health Plan booklet is available at http://www.healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=W9XpPsRWAE8%3d&tabid=61&mid=811.

The 2-1-1 Idaho Care. Line is a toll-free statewide service available to link Idahoans with health or human serice providers and ptragrams and has translation assistance available.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Supports for Participant Direction	**Community Support Services**		
Supports for Participant Direction	**Financial Management Services**		
Supports for Participant Direction	**Support Broker Services**		
Other Service	**Adult Day Health**		
Other Service	**Behavior Consultation/Crisis Management**		
Other Service	**Chore Services**		
Other Service	**Dental Services**		

Service Type	Service		
Other Service	Environmental Accessibility Adaptations		
Other Service	Home Delivered Meals		
Other Service	Non-Medical Transportation		
Other Service	Personal Emergency Response System		
Other Service	Skilled Nursing		
Other Service	Specialized Medical Equipment and Supplies		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Residential habilitation services which consist of an integrated array of individually-tailored services and supports furnished to eligible participants which are designed to assist them to reside successfully in their own homes, with their families, or Certified Family Home. The services and supports that may be furnished consist of the following:

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas:

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities;

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations;

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation,

dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures;
iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are merely diversional or recreational in nature);
v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community;
vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs.
b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf.

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Family Home Provider
Agency	Residential Habilitation Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Individual

Provider Type:
Certified Family Home Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified Family Home certificate as described in Idaho Administrative Code at 16.03.19
Other Standard *(specify):*
a. An individual who provides direct residential habilitation services in his own home must be certified by the Department to operate a certified family home under IDAPA 16.03.19, "Rules Governing Certified Family Homes," and must receive residential habilitation program coordination services provided through the Department, or its contractor, for the residential habilitation services he provides.
b. CFH providers providing residential habilitation services as a DD Waiver provider must meet the following minimum qualifications:
i. Be at least eighteen (18) years of age;
ii.Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service;
iii.Have current CPR and First Aid certifications;
iv. Be free from communicable diseases;
v. Each CFH provider of residential habilitation services assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing, or other Department-approved training.
vi. CFH providers of residential habilitation services who provide direct care and services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" and
vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure.
c. All skill training for CFH providers who are providing residential habilitation services must be provided through the Department or its contractor by qualified intellectual disabilities professional (QIDP) who has demonstrated experience in writing skill training programs.
d.Prior to delivering residential habilitation services to a participant, the CFH provider must complete an orientation training in the following areas as provided by either the Department, or its contractor, or both, and include the following areas:
i. Purpose and philosophy of services;
ii. Service rules;
iii. Policies and procedures;
iv. Proper conduct in relating to waiver participants;
v. Handling of confidential and emergency situation that involve the waiver participant;
vi. Participant rights;
vii. Methods of supervising participants;
viii. Working with individuals with developmental disabilities; and
ix. Training specific to the needs of the participant.
e. Additional training requirements for CFH providers providing residential habilitation waiver services must be completed by the CFH provider within six (6) months of certification date and include a minimum of the following:
i. Instructional Techniques: Methodologies for training in a systematic and effective manner;
ii. Managing behaviors: techniques and strategies for teaching adaptive behaviors;
iii. Feeding;
iv. Communication;
v. Mobility;
vi. Activities of daily living;
vii. Body mechanics and lifting techniques;
viii. Housekeeping techniques; and
ix. Maintenance of a clean, safe, and healthy environment.
f. The Department or its contractor will be responsible for providing on-going training to the CFH provider of residential habilitation specific to the needs of the participant as needed.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare
Frequency of Verification:
Certification for Certified Family Homes is required the year after the initial home certification study and at least every twenty-four (24) months thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency

Provider Type:
Residential Habilitation Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*
As desribed in IDAPA 16.04.17 and 16.03.705

Other Standard *(specify):*
When residential habilitation services are provided by an agency, the agency must be certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and must be capable of supervising the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements:
a. Direct service staff must meet the following minimum qualifications:
i. Be at least eighteen (18) years of age;
ii.Be a high school graduate or have a GED or demonstrate the ability to provide services according to a plan of service;
iii. Have current CPR and First Aid certifications;
iv. Be free from communicable diseases;
v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training.
vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks."
vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure.
b. All skill training for agency direct service staff must be provided by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs.
c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects:
i. Purpose and philosophy of services;
ii. Service rules;
iii. Policies and procedures;
iv. Proper conduct in relating to waiver participants;
v. Handling of confidential and emergency situations that involve the waiver participant;
vi. Participant rights;
vii. Methods of supervising participants;
viii. Working with individuals with developmental disabilities; and
ix. Training specific to the needs of the participant.
d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum:
i. Instructional techniques: Methodologies for training in a systematic and effective manner;
ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors;
iii. Feeding;

iv. Communication;
v. Mobility;
vi. Activities of daily living;
vii. Body mechanics and lifting techniques;
viii. Housekeeping techniques; and
ix. Maintenance of a clean, safe, and healthy environment.
e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare

Frequency of Verification:
Residential habilitiation 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

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Respite Care. Short-term breaks from care giving responsibilities to non-paid care givers. The care giver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. Respite care services may be provided in the participant's residence, the private home of the respite provider, the community, a Developmental Disabilities Agency or an Adult Day Health Facility.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Respite Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of respite care services must meet the following minimum qualifications:
a.Have received care giving instructions in the needs of the person who will be provided the service;
b.Demonstrate the ability to provide services according to a plan of service;
c.Be free of communicable diseases; and
d.Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, “Criminal History and Background Checks.”

Verification of Provider Qualifications

Entity Responsible for Verification:
The Department of Health and Welfare

Frequency of Verification:
At least every two years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:
Respite Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of respite care services must meet the following minimum qualifications:
a.Have received care giving instructions in the needs of the person who will be provided the service;
b.Demonstrate the ability to provide services according to a plan of service;
c.Be free of communicable diseases; and
d.Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks."

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare

Frequency of Verification:
At least every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Service Definition *(Scope):*

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work.
a. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or the IDEA.
b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that are not directly related to a waiver participant's supported employment program.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Supported employment includes activities needed to sustain paid work at or above the minimum wage by participants, including oversight and training. Service payment is made only for the adaptations, oversight and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Idaho's Division of Vocational Rehabilitation assists participants to locate a job or develop a job on behalf of the participant.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Supported Employment Agencies
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks."

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare

Frequency of Verification:
At least every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:
Other Supports for Participant Direction

Alternate Service Title (if any):
Community Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

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:
Job support to help the participant secure and maintain employment or attain job advancement; 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, spouse, or others in order to build a natural support network and community; Emotional support to help the participant learn and practice behaviors consistent with his goals and wishes while minimizing interfering behaviors; Learning support to help the participant learn new skills or improve existing skills that relate to his identified goals; Transportation support to help the participant accomplish his identified goals; Adaptive equipment identified in the participant's plan that meets a medical or accessibility need and promotes his increased independence, and Skilled nursing supports.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Only participants who select the Self-Directed option may access this service. There are no limits on the amount, frequency or duration of these services other than the participant must stay within their prospective individual budget amount.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Support
Individual	Community Support

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Community Support Services

Provider Category:
Agency

Provider Type:
Community Support

Provider Qualifications

License *(specify):*
If required for identified goods or supports. For example, a community support providing skilled nursing must have current nursing licensure.

Certificate *(specify):*
If required for identifed goods or supports. For example, when the community support is providing services in the community support's home, the home must be a certified family home.

Other Standard *(specify):*
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.

Verification of Provider Qualifications

Entity Responsible for Verification:
Participant
Support Broker
The Department of Health and Welfare (during retropsective quality assurance reviews).

Frequency of Verification:
Inital and annually, with review of employment/vendor aggreemetns.

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Community Support Services

Provider Category:
Individual

Provider Type:
Community Support

Provider Qualifications

License *(specify):*
If required for identified goods or supports. For example, a community support providing skilled nursing must have current nursing licensure.

Certificate *(specify):*
If required for identified goods or supports. For example, when the community support is providing services in the community support's home, the home must be a certified family home.

Other Standard *(specify):*
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.

Verification of Provider Qualifications

Entity Responsible for Verification:
Participant
Support Broker
Department of Health and Welfare (during retrospective quality assurance reviews)

Frequency of Verification:
Initally and annually, with review of employment/vendor agreement.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:
Financial Management Services

Alternate Service Title (if any):
Financial Management Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Service Definition *(Scope):*

The

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Department will offer financial management services through any qualified fiscal employer agent (FEA).

FEA providers will complete financial consultation and services for a participant whom has chosen to self 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 self direction to occur:

a. Payroll and Accounting: Providing payroll and accounting supports to participants that have chosen the self directed communitiy supports option.
b. Financial Reporting: Perfoming financial reporting for employees of each participant.
c. Financial information packet: preparing and distributing a packet of information, including Department approved forms for agreements, for the participant hiring his own staff.
d. Time sheets and Invoices: Processing and paying timesheets for community support workers and support brokers, as authorized by the participant, according to the participant's Department authorized support and spending plan.
e. Taxes: Managing and processing payment of required state and federal employment taxes for the participant's community support worker and support broker.
f. Payments for goods and services: Processing and paying invoices for goods and services, as authorized by the participant, according to the participant's support and spending plan.
g. Spending information: Providing each participant with reporting information and data that will assist the participant with managing the indivdual budget.
h. Quality assurance and improvement: Participation in Department quality assurance activities.

FEA providers complete financial services and financial consultation for the participant and/or their representative that is related to a self directed participant's individual budget. The FEA assures that the financial data related to the participant's budget is accurate and available to them or their representative as necessary in order for successful self direction to occur. FEA qualifications and requiremetns and responsiblities as well as allowable activities are described in Idaho Administrative Rules.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
1. Only participants who select the self directed option may access this service.
2. The FEA must not provide any other direct services (including support brokerage) to the participant to ensure there is no conflict of interest; or employ the guardian, parent spouse, payee or conservator of the participant or have direct control over the partipant's choice.
3. The FEA providers may only provide finanical consultation, financial information and financial data to the participant or their representative, and may not provide counseling or information to the participant or their representative about other goods and services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Fiscal Employer/Agent

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:
Agency

Provider Type:
Fiscal Employer/Agent

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The Fiscal Employer Agent (FEA) must meet the requirements outlined in its provider agreement with the Department, and Section 3504 of the Internal Revenue Code. Requirements of the FEA include:
• Obtaining FEIN numbers to file tax forms and make tax payments on behalf of a participant
• Report irregular activities or practices that may conflict with federal or state rules and regulations
• Maintaining a policy and procedures manual
• Providing an SFTP site for the Department to access. The site must have the capability of allowing participants and their employees to access individual specific information such as time cards and account statements
• Preparing, submitting, or revoking IRS forms in accordance with IRS requirement
• Obtaining an Idaho State Tax Commission Power of Attorney (Form TC00110) from each participant it represents
• Revoking the Idaho State Tax Commission Power of Attorney (Form TC00110) when the provider no longer represents the participant
• Providing a customer service system to respond to all inquiries from participants, employees, agencies, and vendors
• Receiving, responding to, and tracking all complaints from any source
• Implementing and enforcing policies and procedures regarding documents that are mailed, faxed, or emailed to and from the provider to ensure documents are tracked and that confidential information is not compromised, is stored appropriately and not lost, and is traceable for historical research purposes.
• Submitting participant enrollment and employee packets to the Department for approval
• Distributing Department-approved participant enrollment packets and employment packets to the participant within two (2) business days after the participant requests the packets.
• Processing payroll, including time sheets and taxes, in accordance with the participant's support and spending plan.
• Tracking and logging time sheet billing errors or time sheets that cannot be paid due to late arrival, missing, or erroneous information. The provider must notify the employee and participant within one (1) business day of when errors are identified on the time sheets.
• Tracking and logging occurrences of improperly cashed or improperly issued checks and must stop payment on checks when necessary.
• Verifying employees' documentation and processing employees' payments via check, direct deposit, or pay cards as per preference of employees
• Processing vendor payments
• Processing independent contractor or outside agency payments.
• Completing end-of-year processing

• Transitioning a participant to a new FEA when requested..
• Conducting an annual participant satisfaction survey
• Providing a Quality Assurance process
• Maintaining a Disaster Recovery Plan for electronic and hard copy files that includes restoring software and data files, and hardware backup if management information systems are disabled or servers are inoperative.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Department of Health and Welfare

Frequency of Verification:
At the time of application, as indicated by a readiness review to be conducted by the Department for all FEA providers and therafter at least every two years by Department review.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:
Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):
Support Broker Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*
Support brokers provide counseling and assistance for participants with arranging, directing, and managing goods and 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 with any assistance they need for gathering and reviewing their budget and finanical data and reports prepared and issued to them by the FEA. Practical skills training is offered to enable participants to remain independent. Examples of skills training include helping participants understand the responsibilties 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 must be specified on the support and spending plan.

Suport broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the partcipant's needs and preferences. At a minium, the support broker must:
Participate in the person centered planning process;
Develop a written support and spending plan with the participant that includes the supports the participant needs and wants, related risks identified with the participant's wants and preference, and a comprehensive risk plan for each potential risk that includes at least three back up plans should a support fall out; Assist the participant to monitor and review his budget through data and finanical information provided by the FEA; Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department; Participate with Department quality assurance measures, as requested. Assist the participant with scheduling required assessments to complete the Department's annual determination process as needed, including assisting the participant or his representative 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:
Assist the participant to develop and maintain a circle of support; help the participant learn and implement the skills needed to recruit, hire and monitor community supports; assist the participant to negotiate rates for paid community support workers; maintain documentation of supports provided by each community support worker and participant's satisfaction with these supports; assist the participant to monitor community supports; assist the participant to resolve employment-related problems; assist the participant to identify and develop community resources to meet specific needs.

Support brokers qualifications, requirements and responsibliites as well as allowable activities are described in Idaho Administrative Rule.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Only participants who select the Self-Directed option may access this service.

Support brokers may not act as fiscal employer agents, instead support brokers work together with the participant to review their financial information that is produced and maintained by the fiscal employer agent.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Support Broker

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Support Broker Services

Provider Category:
Individual

Provider Type:
Support Broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A Support Broker providing services to a participant accessing Consumer Directed Services must meet the following qualifications:

• Be eighteen (18) years of age or older
• Have skills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field
• Have at least two (2) years verifiable experience with the target population and knowledge of services and resources in the developmental disabilities field
• Successfully pass an application exam
• Complete a criminal history check, including clearance in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"
• Complete an employment agreement with the participant that identifies the specific tasks and services that are required of the support broker

All support brokers must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of support broker services.

The support broker must not: Provide or be employed by an agency that provides paid community supports to the same participant; and must not be in a position to both influence a participant's decision making and receive undue financial benefit from the participant's decisions.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare
Participant

Frequency of Verification:

At the time of application, annual review of ongoing education requirement, and by participant when entering into employment agreement.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Day Health

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Service Definition *(Scope):*

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Adult day health is a supervised, structured service generally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week. It is provided in a non-institutional, community-based setting and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Adult Day Health cannot exceed thirty (30) hours per week either alone or in combination with developmental therapy and occupational therapy.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health
Individual	Adult Day Health

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Health

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Adult Day Health services must be delivered through an executed provider agreement with the provider and Medicaid. Providers are reviewed during the initial provider agreement approval and through the renewal process. After the initial provider agreement is approved, providers are reviewed at least every three years, and as needed based on service monitoring concerns.

Providers of adult day health must meet the following:
a. Services provided in a facility must meet the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)."
b. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home".
c. Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks";
d. Providers of adult day health services must notify the Department on behalf of the participant, if the adult day health is provided in a certified family home other than the participant's primary residence. The adult day health provider must be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan
e. Be free from communicable disease

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare
Frequency of Verification:
At least every two years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Day Health

Provider Category:
Individual

Provider Type:
Adult Day Health

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Adult Day Health services must be delivered through an executed provider agreement with the provider and Medicaid. Providers are reviewed during the initial provider agreement approval and through the renewal process. After the initial provider agreement is approved, providers are reviewed at least every three years, and as needed based on service monitoring concerns.

Providers of adult day health must meet the following:
a.Services provided in a facility must meet the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)."
b.Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home".
c.Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks";
d.Providers of adult day health services must notify the Department on behalf of the participant, if

the adult day health is provided in a certified family home other than the participant's primary residence. The adult day health provider must be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan
e.Be free from communicable disease

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare
Frequency of Verification:
At least every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Behavior Consultation/Crisis Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*
This service provides direct consultation and clinical evluation of individuals who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may also be used to provide training and staff development related to the needs of a recipient. These services include the provision of emergency back-up involving the direct support of the individual in crisis.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

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

☐ **Legally Responsible Person**
☑ **Relative**
☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behavior Consultation/ Crisis Management
Agency	Behavior Consultation/ Crisis Management

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Consultation/Crisis Management

Provider Category:
Individual

Provider Type:
Behavior Consultation/ Crisis Management

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers must meet the following:
a. Work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and
b. Must have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or
c. Be a licensed pharmacist; or
d. Be a Qualified Intellectual Disabilities Professional (QIDP).
e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, “Rules Governing Residential Habilitation Agencies.”
f. Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, “Criminal History and Background Checks.”

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare

Frequency of Verification:
At least every two years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Consultation/Crisis Management

Provider Category:
Agency

Provider Type:
Behavior Consultation/ Crisis Management

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers must meet the following:
a. Work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and
b. Must have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or
c. Be a licensed pharmacist; or
d. Be a Qualified Intellectual Disabilities Professional (QIDP).
e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies."
f. Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks."

Verification of Provider Qualifications

Entity Responsible for Verification:
The Department of Health and Welfare

Frequency of Verification:
At least every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Chore Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Chore services include the following services when necessary to maintain the functional use of the home, or to provide a clean, sanitary and safe environment:
a. Intermittent assistance may include the following
i. Yard maintenance;
ii. Minor home repair;
iii. Heavy housework;
iv. Sidewalk maintenance; and
v. Trash removal to assist the participant to remain in their home.

b. Chore activities may include the following:
i. Washing windows;
ii. Moving heavy furniture;
iii. Shoveling snow to provide safe access inside and outside the home;
iv. Chopping wood when wood is the participant's primary source of heat; and
v. Tacking down loose rugs and flooring.

c. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer, agency, or third party payer is willing to, or is responsible for their provision.

d. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Chore Services
Individual	Chore Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:
Agency

Provider Type:
Chore Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of chore services must meet the following minimum qualifications:
a. Be skilled in the type of service to be provided; and
b. Demonstrate the ability to provide services according to a plan of service.
c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks."

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare

Frequency of Verification:
At least every two years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:
Individual

Provider Type:
Chore Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of chore services must meet the following minimum qualifications:
a. Be skilled in the type of service to be provided; and
b. Demonstrate the ability to provide services according to a plan of service.
c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks."

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare
Frequency of Verification:
At least every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Dental Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Dental services include exams, radiographs, diagnostic and preventative services, basic restorations, periodontics, oral surgery, maxillofacial surgery, and adjunctive dental services. These services and the medically necessary dental benefits described in IDAPA 16.03.10 are provided through the Idaho Smiles program. The State's Medicaid dental contract for the Idaho Smiles program includes the complete list of all dental services available to waiver participants. Please refer to the dental benefit table in the "Main-Optional-Additional Needed Information" section of this waiver application for a comprehensive description of services.
a. Coverage must include a provision for a second opinion from a qualified dental care professional within the network, or arrange for a second opinion outside the network, at no cost to the participant. Participants may obtain a second opinion if they believe that they did not receive the appropriate service or diagnosis. The contractor reviews and may approve the request.
b. Waiver dental services are limited to participants who are past the month of their twenty first (21) birthdays. Waiver participants who are under age twenty-one (21) will continue to receive children's dental benefits under the State Plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	DDS, DMD, Oral Surgeon

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Dental Services

Provider Category:
Individual

Provider Type:
DDS, DMD, Oral Surgeon

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers are credentialed by the contractor to ensure they meet licensing requirements of the Idaho Board of Dentistry. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Department has entered into a contract with Blue Cross of Idaho who subcontracts with Dentaquest for a dental insurance program called Idaho Smiles. Idaho Smiles/Dentaquest is responsible for verification of provider qualifications.

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include:
a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning.
b. Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home which is the participant's principal residence and is owned by participant or the participant's non-paid family.
c. Portable or Non-Stationary Modifications. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Environmental Accessibility Adaptations
Individual	Environmental Accessibility Adaptations

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Agency

Provider Type:
Environmental Accessibility Adaptations

Provider Qualifications

License *(specify):*
Licenses or certificates are required when mandated by State or local building codes for particular types of environmental accessibility adaptations. For instance, a provider must have a plumbing license to be permitted to complete plumbing work.

Certificate *(specify):*

Other Standard *(specify):*
Environmental Accessibility Adaptions are delivered through an executed provider agreement with the provider and Medicaid. Providers are reviewed during the initial provider agreement approval process and when services are authorized.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare

Frequency of Verification:
At least every two years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual

Provider Type:
Environmental Accessibility Adaptations

Provider Qualifications

License *(specify):*
Licenses or certificates are required when mandated by State or local building codes for particular types of environmental accessibility adaptations. For instance, a provider must have a plumbing license to be permitted to complete plumbing work.

Certificate *(specify):*

Other Standard *(specify):*
Environmental Accessibility Adaptions are delivered through an executed provider agreement with the provider and Medicaid. Providers are reviewed during the initial provider agreement approval process and when services are authorized.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare

Frequency of Verification:
At least every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*

Meals which are designed to promote adequate participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who: a. Rent or own their own home;
b. Are alone for significant parts of the day;
c. Have no regular caretaker for extended periods of time; and
d. Are unable to prepare a meal without assistance.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Delivered Meals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency

Provider Type:
Home Delivered Meals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers must be a public agency or private business and must be capable of:
a. Supervising the direct service;
b. Providing assurance that each meal meets one-third (1/3) of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences;
c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food;
d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and
e. Being inspected and licensed as a food establishment by the District Health Department.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare

Frequency of Verification:
At least every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Non-Medical Transportation

HCBS Taxonomy:

Service Definition *(Scope):*

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Non-medical transportation enables a waiver participant to gain access to waiver and other community services and resources.
a. Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace it.
b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge, or public transit providers will be utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Non-MedicalTransportation

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency

Provider Type:
Non-MedicalTransportation

Provider Qualifications

License *(specify):*
Driver's License

Certificate *(specify):*

Other Standard *(specify):*
Non-Medical Transportation Services. Providers of non-medical transportation services must:
a. Possess a valid driver's license; and
b. Possess valid vehicle insurance

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Personal Emergency Response System

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

This service is limited to participants who:
a. Rent or own their home, or live with unpaid caregivers;
b. Are alone for significant parts of the day;
c. Have no caretaker for extended periods of time; and
d. Would otherwise require extensive routine supervision.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response System

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Agency

Provider Type:
Personal Emergency Response System

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare

Frequency of Verification:
At least every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Skilled Nursing

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Intermittent or continuous oversight, training, or skilled care which is within the scope of the Nurse Practice Act and as such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. Nursing services may include but are not limited to:
a. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material;
b. The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning.
c. Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis;
d. Injections;
e. Blood glucose monitoring; and
f. Blood pressure monitoring.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Skilled Nurse
Agency	Skilled Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual

Provider Type:
Skilled Nurse

Provider Qualifications

License *(specify):*
Nursing Service Providers must be licensed in Idaho as an R.N. or L.P.N. in good standing, or must be practicing on a federal reservation and be licensed in another state.

Certificate *(specify):*

Other Standard *(specify):*
Nursing service providers must adhere to requirements specified in IDAPA 23.01.01.400-401

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare

Frequency of Verification:
At least every two years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Agency

Provider Type:
Skilled Nurse

Provider Qualifications

License *(specify):*
Nursing Service Providers must be licensed in Idaho as an R.N. or L.P.N. in good standing, or must be practicing on a federal reservation and be licensed in another state.

Certificate *(specify):*

Other Standard *(specify):*
Nursing service providers must adhere to requirements specified in IDAPA 23.01.01.400-401

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare

Frequency of Verification:
At least every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Service Definition *(Scope):*

Specialized medical equipment and supplies includes devices, controls, or appliances which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Medical Equipment and Supplies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency

Provider Type:
Specialized Medical Equipment and Supplies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. Providers must ensure all items must meet applicable standards of manufacture, design and installation. Preference will be given to equipment and supplies that are the most cost effective option to meet the participant's needs.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Welfare

Frequency of Verification:
At least every two years.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Participants who select traditional waiver services receive case management through Service Coordination as described in IDAPA 16.03.10.720 through 779. Service Coordination is a case management activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the

needs of the individual. Service coordination includes plan assessment and periodic re-assessment, development of a plan, referral activities, monitoring activities that ensure the participant's plan is implemented and adequately addresses the participant's needs, and crisis assistance. In order to ensure there is no conflict of interest, Service Coordinators may not provide both service coordination and direct services to the same participant.

Participants who select Consumer Directed Services receive case management through a Support Broker as described in IDAPA 16.03.13.135 through 136. Within these rules a Support Broker is defined as an individual who advocates on behalf of the participant and who is hired by the participant to assist with planning, negotiating and budgeting. Support broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant's needs and preferences. At a minimum the Support Broker must: Participate in the person-centered planning process; Develop a written support and spending plan with the participant that includes the paid and unpaid supports that 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 (3) backup plans should a support fail. This plan must be authorized by the Department; Assist the participant to monitor and review his budget; Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department; Participate with Department quality assurance measures, as requested; Assist the participant to complete the annual re-determination process as needed, including updating the support and spending plan and submitting it to the Department for authorization; Assist the participant, as needed, to meet the participant responsibilities and assist the participant, as needed, to protect his own health and safety; and Complete the Department-approved criminal history check waiver form when a participant chooses to waive the criminal history check requirement for a community support worker.

In addition to the required support broker duties, each support broker must be able to provide the following services when requested by the participant: Assist the participant to develop and maintain a circle of support; Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports; Assist the participant to negotiate rates for paid community support workers; Maintain documentation of supports provided by each community support worker and participant's satisfaction with these supports; Assist the participant to monitor community supports; Assist the participant to resolve employment-related problems; and Assist the participant to identify and develop community resources to meet specific needs.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All traditional waiver service providers that provide direct care or services to participant must satisfactorily complete a criminal history and background check (completed by the Criminal History Unit of DHW) in accordance with Idaho Administrative Code IDAPA 16.05.06, "Criminal History and Background Checks."

Criminal History Checks review information obtained from the Federal Bureau of Investigation, the National Criminal History Background Check System, the Idaho State Police Bureau of Criminal Identification, the statewide Child Abuse Registry, the Adult Protection Registry, the Sexual Offender Registry, and the Medicaid Surveillance and Utilization Review exclusion list.

Traditional waiver service providers sign a written agreement to comply with all rules and regulations relevant to the services they provide including compliance with IDAPA 16.05.06. Criminal history background checks are also reviewed during retrospective quality assurance surveys conducted by the Department.

Participants who select consumer directed services may choose to waive the criminal history and background check for community support workers. When a participant chooses to waive this requirement, the choice must

be documented in writing and is maintained by the Fiscal Employer Agent. The documentation of the waived criminal history and background check requires that the support broker documents education and counseling provided to the participant and his circle of support regarding the risks of waiving a criminal history check and that the support broker assisted with detailing the rationale for waiving the criminal history check. This documentation must be signed by the participant, the legal guardian (if applicable) and support broker. The documentation must state;
1. Why the participant is waiving the criminal history check,
2. How the participant will assure health & safety without obtaining the criminal history check, and
3. That the participant understands the risk with waiving the criminal history check and accepts this increased risk.

Additionally, the Department will monitor criminal history and background check waivers by participants who have selected consumer directed services in the following ways:
• Participant experience surveys will include a sampling of participants who have waived the criminal history check for a community support worker.
• The Department will receive a list of criminal history check waivers from the Fiscal Employer Agent.
• The Department will conduct a search of the complaint/incident database for any complaints or incidents associated with the participants and community support workers who have a criminal history check waiver.
• Quality Oversight Reports to the Quality Oversight Committee will include an analysis of the impact of this waiver process.

Criminal History and Background Checks are required of all support brokers for participants who select consumer directed services. Prior to reimbursement for services to a participant who selects consumer directed services, the support broker and community support workers, must submit a copy of the clearance letter received from the Department's Criminal History Check Unit or a copy of the completed criminal history background check waiver, as applicable

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Idaho Department of Health & Welfare, Division of Family & Children's Services is responsible for maintaining the Child Abuse Registry. The Adult Protection Registry is maintained by the Idaho Commission on Aging.

Providers that require abuse registry screening are the same as those providers requiring criminal history checks. Criminal History and Background Checks, completed by the IDHW Criminal History Unit, include a review of the abuse registries.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ( ) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- (●) **Other policy.**

Specify:

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3, except support brokers who must not be the guardian, parent, spouse, payee or conservator of the participant. There are numerous safeguards in place to ensure that payments are only made for services rendered including oversight by provider agencies, person-centered planning teams, circles of supports, fiscal/employer agent, and by the Department through review and

approval of proposed plans of care and retrospective quality assurance reviews.

All providers are precluded from being in a position to both influence a participant's decision making and benefit financially from these decisions. Payments for services rendered are made only after review and approval by the participant 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.

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Department permits continuous, open enrollment of all willing and qualified waiver service providers. Waiver service providers are not selected through an RFP process that limits the number of providers and do not have additional contracting requirements or other qualifications that are unnecessary to ensure that services are performed in a safe and effective manner.

Provider enrollment information and forms are continuously available via the Internet. In order to enroll, providers must submit their enrollment application to Molina Medicaid Solutions through an electronic application form. Provider enrollment help is available through a toll free number given to interested provider applicants. If providers have additional questions, they may also contact the local Medicaid office or Medicaid Program Manager who is designated to assist with provider enrollment issues.

Lists of current providers are available from the IAP and regional offices. Provider qualifications and requirements are published in the Department's Administrative Rules and are available online at http://adm.idaho.gov/adminrules/rules/idapa16/16index.htm. Specific Medicaid provider information, including provider handbooks and provider enrollment information, is available on the Department of Health and Welfare website at www.healthandwelfare.idaho.gov, by clicking on the "Medicaid Provider Information" button.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Qualified Providers**
   i. **Sub-Assurances:**

      a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

      Performance Measures

      For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

      For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

      Performance Measure:
      Number and percent of initial HCBS DD Waiver providers that meet required licensure or certification standards a. Numerator: Number of initial HCBS DD waiver providers that meet required licensure or certification standards b. Denominator: Number of initial HCBS DD waiver providers

      Data Source (Select one):
      Provider performance monitoring

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
2. Number and percent of ongoing HCBS DD waiver providers who meet licensure and certification requirements. a. Numerator: Number of ongoing HCBS DD waiver providers that meet required licensure or certification standards b. Denominator: Number of ongoing HCBS DD waiver providers

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Residential habilitiation 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	

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

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

Data Aggregation and Analysis:

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

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new providers that have an initial provider review within 6 months of providing services to waiver participants. a. Numerator: Number of initial providers who have a review within 6 months of providing services to waiver participants b. Denominator: Number of initial providers

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of HCBS DD waiver providers who received an on-site review every two years. a. Numerator: Number of DD waiver providers who received an on-site review every two years b. Denominator: Number of HCBS DD waiver providers

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

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

		☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Every two years	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of DD waiver direct care staff that meet state requirements for training. a. Numerator: Number of DD waiver direct care staff reviewed that meet state requirements for training b. Denominator: Number of DD waiver direct care staff reviewed

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participants who have the opportunity to provide feedback to the Department regarding Medicaid HCBS DD providers. a. Numerator: Number of participants who have the opportunity to provide feedback to the Department regarding Medicaid HCBS DD providers b. Denominator: Number of participants receiving HCBS DD waiver services

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Medicaid BDDS Quality Manager is responsible for QA remediation and system improvement processes and reporting.

The Division of Medicaid Bureau of Developmental Disability Services Quality Oversight Committee, (comprised of Quality Manager, BDDS Data Analyst, Quality Team representatives, BDDS Care Manager representatives, BDDS Policy Staff)is responsible for review of data and Annual BDDS LOC Report findings, identification of remediation activities, and monitor of ongoing system improvement initiatives and activities. Recommendations are submitted to BDDS Bureau Chief for consideration.

The Division of Medicaid BDDS Management Team is responsible for identifying and addressing any statewide resource or program issues identified in QA business processes. Reports are analyzed and the result of the analysis is reported to the BDDS Bureau Chief. Recommended program changes or system improvement processes are sent to the Central Office Management Team (COMT) for approval.

Medicaid's Central Office Management Team (COMT)is responsible for reviewing BDDS and other

Medicaid program report analyses and recommendations, considering Division wide resources and coordination issues and strategies and making final system wide change decisions

ii. **Remediation Data Aggregation**
Remediation-related Data Aggregation and Analysis (including trend identification)

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

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

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.

A calculation tool establishes a budget based on information entered on an Inventory of Individual Needs, an assessment tool designed to capture the participant's functional abilities, behavioral limitations, medical needs and other individual factors related to their developmental disability. The tool is based on a regression analysis model which calculates a budget that correlates with each participant's individualized needs.

The budget tool is periodically evaluated and adjusted to ensure participant budgets are calculated using information that produces the greatest statistical validity when analyzing participant need and cost of services.

To ensure a participant's budget is adequate to meet their individual needs, Idaho provides the following safeguards: 1) When the participant is noticed regarding their budget amount they have the opportunity to appeal that budget within 28 days of the date on the eligibility notice. When the appeal is received it is reviewed by the Department to ensure all the participant's needs were accurately captured through responses on the inventory of individual needs and the participant does not have needs outside of what is captured by the inventory that meet medical necessity criteria. If medically necessary needs not addressed by the inventory are identified, dollars to meet those needs are added to the budget. Individualized budgets will be re-evaluated annually. 2) At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's condition resulting in a need for services that meet medical necessity criteria, and this is not reflected on the current inventory of individual needs. When the Department determines there has been a documented change in condition not reflected on the current inventory, a new inventory is completed and budget calculated for the participant. The participant has the right to appeal this new budget. 3) A participant may submit a service plan requesting a combination of DD services that exceed their annual calculated budget if the participant is eligible for, and intends to receive, High or Intense Residential Habilitation Supported Living services, and the combination of services on the plan is necessary to ensure the health and safety of the participant.

☐ **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.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Support Plan or Support and Spending Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
   - ☐ **Registered nurse, licensed to practice in the State**
   - ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

☐ **Social Worker.**

Specify qualifications:

☑ **Other**

Specify the individuals and their qualifications:

In Idaho, adult participants age eighteen (18) or older who meet DD eligibility criteria are provided the option to select either a paid or unpaid plan developer to develop their initial/annual plan.

For individuals who select traditional waiver services, paid plan developers must meet service coordination qualifications as defined 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.

A service coordinator providing services to a participant accessing traditional DD Waiver services must meet the following qualifications:
• Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department; and
• Minimum of a Bachelor's degree in 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; and
• 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."; and
• The total caseload of a service coordinator must assure quality service delivery and participant satisfaction.

For individuals who select consumer directed services, plan development is completed by the support broker. Support brokers must meet qualifications as defined in IDAPA 16.03.13.135.

A Support Broker providing services to a participant accessing Consumer Directed Services must meet the following qualifications:
• Be eighteen (18) years of age or older
• Have skills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field
• Have at least two (2) years verifiable experience with the target population and knowledge of services and resources in the developmental disabilities field
• Successfully pass an application exam
• Complete a criminal history check, including clearance in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"
• Complete an employment agreement with the participant that identifies the specific tasks and services that are required of the support broker

All support brokers must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of support broker services.

The support broker must not: Provide or be employed by an agency that provides paid community supports to

the same participant; and must not be in a position to both influence a participant's decision making and receive undue financial benefit from the participant's decisions.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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. Additional information is provided to participants on the traditional service and consumer directed service options. For families interested in consumer directed services, the Department offers an orientation and a "My Voice My Choice" training.

For participants who select traditional waiver services, 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.

Participants who select consumer directed services must choose a qualified support broker to assist with writing the Support and Spending Plan. As outlined in IDAPA 16.03.13, "Consumer-Directed Services," the participant decides who will participate in the planning sessions in order to ensure the participant's choices are honored and promoted. The participant may direct the person-centered planning meetings, or these meetings may be facilitated by the chosen support broker. In addition, the participant selects a circle of support. Members of the circle of support commit to work within the group to: help promote and improve the life of the participant in accordance with the participant's choices and preferences; and meet on a regular basis to assist the participant to accomplish his/her expressed goals.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

After the Department notifies each participant of their set budget amount as part of the eligibility determination process or annual determination process, the participant determines if they want to select traditional waiver or consumer directed services.
For participants who select traditional waiver services, the plan of service is developed by the participant and their person centered planning team. For participants who select consumer directed services the plan of service is developed by the participant, support broker and the circle of support.

The number of people who can be involved is not limited. The participant, the plan developer or support broker and legal guardian if applicable are the only people who are required to be a part of plan development process.

For participants selecting traditional waiver services, each Individual Service Plan (ISP) must be submitted to the Department at least 45 days prior to the expiration of the current ISP in accordance with IDAPA 16.03.10. The Department has thirty (30) days to review the plan, discuss any issues with the plan developer, and request changes as needed. The Department has an additional fifteen (15) days to enter the authorizations for approved services into the MMIS system.

Participants who select consumer directed services submit their Support and Spending Plan (SSP) directly to the Department for review and authorization. The Department has ten (10) days to review the plan, discuss any issues with the support broker, and request changes as needed. The Department has an additional five (5) days to enter the authorizations for the approved services into the MMIS system.

Written notification of plan approval or denial is sent to the participant. As part of this notification, participants receive information on how to appeal the Department's decision.

The independent assessment provider conducts and collects a variety of assessments and determines the participant's individualized budget at the time of initial application and on an annual basis. These assessments are used to secure information and support the service plan development process.
At the time of initial application for adult DD services, the independent assessment provider conducts and/or obtains the following assessments:
• Functional assessment - Scales of Independent Behavior-Revised (SIB-R)
• Medical, social and developmental assessment summary
• Physician's health and physical from the participant's Primary Care Physician

At the time of the annual re-determination, the IAP reviews and/or updates the following:
• Scales of Independent Behavior-Revised (SIB-R) - SIB-R results are reviewed and another assessment is conducted if reassessment criteria is met:
• The medical, social and developmental assessment summary
• A health and physical. This information is required and provided to the IAP on an annual basis.

The following assessments may be obtained as needed to determine initial DD and/or ICF/ID level of care eligibility and to calculate an individual budget:
• Psychological evaluations
• Supplemental Medical Assessment
• Risk Assessment

Participants, guardians, and other members of the support team can receive information regarding the waiver services through several methods:
• The Department of Health and Welfare web site for Adult DD Care Management has a page giving a detailed explanation for each service provided under the Waiver.
• The Independent Assessor has a list of all waiver services with a description of what each service entails. During the eligibility process the assessor can provide this information to the family and may explain options to initial applicants.
• During the eligibility process, the independent assessor provides each new applicant with a Consumer Tool Kit which includes a listing of agencies in the local area that provide services, including plan development, service coordination, residential habilitation, and developmental disabilities agency services.
• For participants selecting traditional waiver services, the plan developer and service coordinator is charged with verbally explaining the various programs and options to the participant during the person-centered planning process, under the traditional option.
• For participants selecting consumer directed services, the support broker is charged with assisting the participant to assess what services meet their needs.

Idaho requires that a person centered-planning process be utilized in development of the plan to ensure that participant goals, needs and preferences are reflected on the ISP or on the Support and Spending Plan. An ISP manual was developed by the Department and is used by plan developers statewide. The manual provides details on addressing participant goals, needs, and preferences.

Participants who select consumer directed services must attend a "My Choice My Voice" training prior to submitting their first Support and Spending Plan. Completion of this training is documented in the Department's quality assurance database. The training covers participant responsibilities and the process of developing a Support and Spending Plan. The consumer directed option utilizes the My Voice My Choice 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.

Waiver participants typically receive a variety of waiver services, State Plan services, and other supports to address their wants and needs. The person-centered planning team works to ensure that the plan adequately reflects all necessary services.

For participants who select traditional waiver services, the plan developer and Department staff that authorize the plan are responsible to ensure that services are coordinated.

• The plan developer is responsible to work with the members of the person-centered planning team and providers to ensure that the service needs of the participant are reflected on the ISP.
• The plan developer is responsible to ensure that services are not duplicative.
• Department staff are responsible to review each ISP submitted by the plan developer to ensure that the participant's needs are addressed by the plan and services are not duplicative.

For participants who select consumer directed services, the participant and the circle of supports use the My Voice My Choice Workbook and the person-centered planning process to identify participant needs and develop a Support and Spending Plan that meets the participant's needs.

• The support broker writes the Support and Spending Plan to reflect the needs and wants of the participant.
• Department staff reviews the plan to ensure that all health and safety requirements are met.
• The Fiscal Employer Agent (FEA) ensures that duplication of payment does not occur.

Participants selecting traditional waiver services must choose a plan monitor as outlined in IDAPA 16.03.10. The person-centered planning team identifies the frequency of monitoring but at a minimum it must occur at least every ninety (90) days. In addition, the plan must be monitored for continuing quality. Plan monitoring ensures that the ISP addresses the participant's goals, needs and preferences by requiring:
• Face to face contact with the participant at least every ninety (90) days to identify the current status of the program and changes if needed.
• Contact with service providers to identify barriers to service provision.
• Discuss satisfaction regarding quality and quantity of services with the participant.
• Review of provider status reports for annual plan development.
• Report any suspicion or allegation of abuse, neglect or exploitation to the appropriate authorities including the Department.

Participants who select consumer directed services may choose to assume the responsibility of plan monitoring themselves, utilize members of the circle of supports, or require the support broker to perform these duties. Plan monitoring is assigned during the person-centered planning process and is reflected in the My Voice My Choice Workbook.

At a minimum, a Support Broker would have face-to-face contact with the participant when providing the following required duties:
• Participate in the annual person-centered planning meeting;
• Assist the participant to complete the annual re-determination process as needed, including updating the support and spending plan and submitting it to the Department for authorization.
Any other face-to-face contact outside of the support broker duties required by rule would be at the discretion of the participant.

Each participant is required to submit a new plan annually. The IAP sends written notification 120 days prior to the expiration of the current plan. The notice requests that the participant, and anyone they choose to help or represent them, schedule a meeting with the IAP to begin the process of eligibility re-determination, annual budget

determination and plan development.

The plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on a change to a cost, addition of a service or increase to a service, or a change of provider. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Person-Centered Planning and Plan Development
Risk assessment is included as part of the person-centered planning process. Team members identify risks while developing the Individual Support Plan or Support and Spending Plan. Emergency back-ups and plans to mitigate identified risks are identified on both plans. For participants who select traditional waiver services and need a health and safety plan, specific implementation plans are developed by providers or the contractor.
For participants who select consumer directed services, back-up plans are included in the Support and Spending plan. Support brokers are required to include a comprehensive risk plan for each potential risk identified with the participant's wants and preferences. This plan must include at least three backup plans for each identified risk to implement in case the need arises. To assist with identification of risks, the Department includes in each participant's plan a health and safety checklist in the personal summary section. Plan developers document any potential risks in this document, as well as identify how these risks will be mitigated. The Individual Support Plan includes any medical issues, supervision needs, abuse risks, risks that result from behavior issues with the participant, exploitation risks, and financial risks. Along with identification, the form also identifies how the risk is being mitigated.

Community Crisis Supports
The Department also has community crisis supports. These supports include; intervention for participants in crisis situations to ensure health and safety, loss of housing, employment or reduction of income, risk of incarceration, risk of physical harm, family altercation or other emergencies specific to the participant. 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.

Provider Agencies
Provider agencies are responsible to provide for quality assurance and health and safety for the participants they serve. Provider agreements and IDAPA rule require Medicaid providers to supply safe, effective services and have processes in place to assure quality.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

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 families in selecting service providers at the family’s request.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

For participants who select traditional waiver services, the plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team identifies the frequency of monitoring, which must be at least every ninety days.
Plan monitoring activities include the following:
• Review of the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed.
• Contact with service providers to identify barriers to service provision.
• Discuss with participant satisfaction regarding quality and quantity of services.
• Review of provider status reviews.
The provider will immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as

well as injuries of unknown origin to the agency administrator, the Department, the adult protection authority, and any other entity identified under Idaho Code, or federal law.

Participants who select consumer directed services are responsible for monitoring services with the assistance of the circle of supports. Participants may also choose to employ their support broker to perform some or all of these monitoring activities. The participant and circle of supports determine the frequency and methods for monitoring. At a minimum, a Support Broker would have face-to-face contact with the participant when providing the following required duties:
• Participate in the annual person-centered planning meeting;
• Assist the participant to complete the annual re-determination process as needed, including updating the support and spending plan and submitting it to the Department for authorization.
Any other face-to-face contact outside of the support broker duties required by rule would be at the discretion of the participant. The Department reviews the proposed Support and Spending Plan. If this plan does not detail sufficient monitoring to protect the participant's health and safety, the Department will require additional detail and appropriate changes to the proposed plan prior to authorization.

The Department investigates all critical incidents and complaints. In addition, the Department conducts ongoing quality assurance outcome reviews and reviews a statistically-valid sample of all waiver participants.

Participants who choose traditional services request adjustments to their Individual Service Plan (ISP) during the plan year through the Addendum process. These adjustments must be based on a change to a cost, addition of a service or increase to a service, or a change of provider. Additional assessments or information may be clinically necessary. Adjustment of the ISP through an Addendum is subject to prior authorization by the Department. At the request of the participant, if there are documented changes in the participant's condition resulting in a need for additional services that meet medical necessity criteria, the Department will re-evaluate the participant's set budget amount in order to allow a request for these services through the Addendum process.

Participants who choose consumer-directed services request adjustments to their Support and Spending Plan (SSP) during the plan year through the Plan Change process. These adjustments must be based on a change in cost associated with any support category initially approved on the SSP, or adding or subtracting a service in a support category. Adjustment of the SSP through a Plan Change is subject to prior authorization by the Department. At the request of the participant, if there are documented changes in the participant's condition resulting in a need for additional services that meet medical necessity criteria, the Department will re-evaluate the participant's set budget amount in order to allow a request for these services through the Plan Change process.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of service plans reviewed who had service plans that were adequate and appropriate to their needs (including health care needs) as indicated in the assessment(s). a. Numerator: Number of plans reviewed that were adequate and appropriate to the participant's needs as indicated in the assessment b. Denominator: Number of plans reviewed (based on 95% representative sample)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of service plans that address participants' goals as indicated in the assessments(s). a. Numerator: Number of service plans reviewed that address participants' goals as indicated in the assessment b. Denominator: Number of service plans reviewed (based on 95% representative sample)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant experience/satisfaction survey respondents who reported unmet needs (or unmet need in a given ADS, IADL, or other area defined by the state). a. Numerator: Number of participant experience/satisfaction survey respondents who reported unmet needs b. Denominator: Number of participant experience/satisfaction survey respondents

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of participants reviewed whose service plans had adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s). a. Numerator: Number of participants reviewed whose plans had adequate and appropriate strategies to address their health and safety risks as indicated in the assessment b. Denominator: Number of participants reviewed

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of service plans reviewed that were submitted to the Department prior to the expiration of the current plan of service. a. Numerator: Number of service plans reviewed that were submitted to the Department prior to the expiration of the current plan of service b. Denominator: Number of service plans reviewed

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of service plans that are updated/revised when warranted by changes in the waiver participant's needs/goals. a. Numerator: Number of service plans that are updated/revised when warranted by changes in the waiver participant's needs/goals b. Denominator: Number of service plans reviewed (based on 95% representative sample)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

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

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

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

	☐ **Continuously and Ongoing**	☑ **Other** Specify: During the survey process, 10% of files are reviewed to ensure plan modifications occur when needed and in a timely manner
	☑ **Other** Specify: Every two years	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of service plans reviewed that indicate services were delivered consistent with the service type, scope, amount, duration and frequency approved on service plans. a. Numerator: Number of plans reviewed that indicate services were delivered consistent with the approved on plans b. Denominator: Number of plans reviewed (based on 95% representative sample)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: During the survey process, 10% of files are reviewed to ensure services are being delivered that are consistent with the plan.
	☑ **Other** Specify: Every two years	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver service plans reviewed and approved that indicated the participant made a choice between waiver services and institutional care. a.Numerator: Number of service plans reviewed and approved that indicated the participant made a choice between waiver services and institutional care b.Denominator: Number of service plans reviewed

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
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 (based on 95% representative sample)

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Bureau of Developmental Disability Services uses a variety of strategies to discover/identify problems/issues within the waiver program that are detailed below:

1. The participant eligibility and budget calculation processes are implemented by the Independent Assessment Providers, (IAPs). Clinical Supervisors train, monitor and supervise IAPs to insure eligibility tools and budget calculations are consistently administered. All participant records are maintained in an IAP database which is monitored by the IAP Quality Assurance Specialist. Monthly, Quarterly and Annual IAP reports are submitted by the IAP Quality Assurance Specialist to the Division of Medicaid Contract Monitor. The Contract Monitor reviews the reports to insure contract compliance with defined benchmarks.

2. BDDS Quality Assurance Specialists conduct biennial Quality Assurance Reviews of all Service Coordination/Plan Monitor providers. The Quality Review insures that the provider is meeting the minimum qualifications to conduct the approved Medicaid service. The Department has provided instructional manuals and forms for the plan monitor to utilize in the development of a participant Individual Support Plan. Updated processes are also communicated by the Department to these providers using World Wide Web technology. Combined the instructional materials and Quality Assurance Reviews insures that plan developers are rendering and submitting consistent and appropriate Individual Support Plans to BDDS for consideration.

During biennial Provider Quality Assurance Reviews, Regional Quality Assurance staff also conducts

random participant file reviews in each agency and insures that the provider is managing all required processes and procedures correctly. A MMIS Service Utilization report is generated for each reviewed participant and services are compared to provider billing to insure accurate and adequate service provisions are being rendered.

3. Once Individual Support Plans are submitted to BDDS for review and approval, BDDS Quality Assurance staff review each ISP individually to insure participant plans are complete. BDDS Care Managers then review each participant plan to insure plans adequately meet the needs of the participant and that all healthy and safety considerations have been adequately addressed prior to approval. BDDS Quality Assurance Staff and Care Managers are supervised by BDDS Program Managers. Through supervision and consultation, the BDDS Management Team insures plans are consistently and correctly reviewed and that Care Manager actions, (approval, denial, negotiation), are within established guidelines.

The BDDS Managers, BDDS Quality Manager, and the BDDS Operations Manager meet on a weekly basis with the BDDS Bureau Chief to discuss identified inconsistencies and to develop and implement remediation procedures to insure continued consistency throughout the participant plan and service review processes.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Medicaid BDDS Quality Manager is responsible for QA remediation and system improvement processes and reporting.

The Division of Medicaid's Bureau of Developmental Disability Services, Quality Oversight Committee, (comprised of Quality Manager, BDDS Data Analyst, Quality Team representatives, BDDS Care Manager representatives and BDDS Policy Staff) is responsible for review of data and Annual BDDS LOC Report findings, identification of remediation activities, and monitor of ongoing system improvement initiatives and activities. Recommendations are submitted to BDDS Bureau Chief for consideration.

Division of Medicaid, BDDS Management Team is responsible for identifying and addressing any statewide resource or program issues identified in QA business processes. Reports are analyzed and the result of the analysis is reported to the BDDS Bureau Chief. Recommended program changes or system improvement processes are sent to the Central Office Management Team (COMT) for approval.

Medicaid's Central Office Management Team (COMT) is responsible for reviewing BDDS and other Medicaid program report analyses and recommendations, considering Division wide resources and coordination issues and strategies and making final system wide change decisions.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

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

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**
  Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (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 waiver's approach to participant direction.

Idaho's consumer directed services option provides a more flexible system, enabling participants to exercise more choice and control over the services they receive which helps participants live more productive and participatory lives within their home and communities. This option is provided within the existing system so that it is sustainable and reflects the value of this option for all waiver participants who choose to direct their own services and supports. The process supports participants' preferences and honors their desire to self-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 the DD waiver, an individualized budget is developed for each participant that incorporates a budget methodology which is calculated consistently. The budget model provides participants with an individual budget and a maximum level of funding that varies according to individual needs. This allows for spending flexibility within the set budgeted dollars according to participants needs and preferences. The support need is determined from an evaluation completed using a uniform assessment tool. Upon completion of an individual participant's individual assessment, the individualized budget methodology which the Department uses to determine an individual's budget is reviewed with the participant either by an IAP representative or a DHW staff.

Participants then have the option to select consumer directed services. This option is offered statewide. Consumer directed services allows eligible participants 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. Through consumer directed services, participants select and hire a trained support broker to help plan, access, negotiate, and monitor their chosen services to their satisfaction. The support broker assists them to make informed choices, participate in a person-centered planning process, and become skilled at managing their own supports. The support broker possesses skills and knowledge that go beyond typical service coordination. Support broker services are included as part of the community support services that participants may purchase out of their allotted budget dollars. The support broker assists participants to convene a circle of supports team and engages in a person-centered planning process. The circle of supports team assists a participant to plan for and access needed services and supports based on their wants and needs within their established budget.

Participants have 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. With the assistance of the support broker and legal representative, if one exists, participants are responsible for the following:

Accepting and honoring the guiding principles of self-direction to the best of their ability.

Participating in the person 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.

Participants, with the help of their support broker, must develop a comprehensive support and spending plan based on the information gathered during the person 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.

Self-directed community supports focuses on participants wants, needs, and goals in the following areas: (1) personal health and safety including quality of life preferences, (2) securing and maintaining employment, (3) establishing and maintaining relationships with family, friends and others to build the participant's natural support community, (4) learning and practicing ways to recognize and minimize interfering behaviors, and (5) learning new skills or improving existing ones to accomplish set goals.

They also identify support needs in the areas of: (1) medical care and medicine, (2) skilled care including therapies or nursing needs, (3) community involvement, (4) preferred living arrangements including possible roommate(s), and (5) response to emergencies including access to emergency assistance and care.

Participants choose support services, categorized as "consumer directed community supports," that will provide greater flexibility to meet the participant's needs in the following areas:

My Job Needs– focuses on assisting an individual in securing and maintaining employment or job advancement, alternate specialized funding and budgeting skills. (Under the traditional model, these needs are met by: community supported employment, transportation, environmental accessibility adaptations, personal assistance, and behavioral consultation/crisis management).

My Personal Needs - focuses on identifying supports and services needed to assure the person's health, safety, and basic quality of life. (Under the traditional model, these needs are met by: personal care services, residential habilitation, chore services, skilled nursing, home delivered meals, developmental therapy, specialized medical equipment and supplies, and personal emergency response systems).

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. (Under the traditional model, these needs are met by: residential habilitation, environmental accessibility adaptations, respite care, chore services, adult day care, and transportation).

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. (Under the traditional model, these needs are met by: residential habilitation, personal emergency response systems, and behavior consultation/crisis management).

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. (Under the traditional model, these needs are met by: residential habilitation, environmental accessibility adaptations, transportation, chore services, personal emergency response systems, home delivered meals, and adult day care).

With the assistance of their Support Broker, participants hire community support workers or enter into vendor agreements to access needed services and supports from these areas, as identified in their support and spending plan.

Participants selecting consumer directed services will be required to choose a qualified financial management services provider, to provide Financial Management Services for them and to process and make payments to community support workers for the community supports and services contained in their support and spending plan. Financial management service 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 or waivers and providing access to spending reports to the participant and the support broker. 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.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☑ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The Department holds regular informational meetings where participants can learn about self-direction. Participants are also provided with informational materials during their initial and annual eligibility determinations by the Department's contractor. These materials include a self assessment tool and information about selecting either the traditional waiver services or consumer directed services. Eligibility notices also include information on traditional waiver and consumer directed services.

The self-assessment tool provided during the eligibility process helps participants assess potential benefits, risks and responsibilities with selecting consumer directed services. Participants who express interest in consumer directed services are required to attend a "Guide to a Self Directed Life" with Department staff. At this meeting, participants receive a consumer toolkit that guides them through the self-direction process of selecting a support broker, hiring community support workers, and utilizing Financial Management Services.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ◉ **The State does not provide for the direction of waiver services by a representative.**
- ○ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☐ **Waiver services may be directed by a legal representative of the participant.**
- ☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C1/C3**

The waiver service entitled:
Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The Department enters into provider agreements with any qualified financial management service provider to provide financial management services to participants who select consumer directed services. Entities that furnish financial management services must be qualified to provide such servcies as indicated in section 3504 of the internal revenue code.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

One flat fee payment per member per month paid using the participant's individual budget.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assists participant in verifying support worker citizenship status**
- [x] **Collects and processes timesheets of support workers**
- [x] **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [x] **Maintains a separate account for each participant's participant-directed budget**
- [x] **Tracks and reports participant funds, disbursements and the balance of participant funds**
- [x] **Processes and pays invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **Other**

Specify:

• Maintains copies of licenses or certification for community support workers as required

• Maintains employment agreements for each community support worker

• Obtains/maintains background check documentation, or documentation of the waived criminal history and background check if applicable, signed by the participant or legal guardian and support broker

• Prepares and distributes a packet of information, including approved forms for agreements, for the participant hiring his own staff

• Participates in Department quality assurance activities

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Department enters into provider agreements with qualified providers to perform financial management services for participants who select consumer directed services. Financial management provider duties and responsibilities are outlined in IDAPA 16.03.13.300 through 314.

The Department monitors the activities of each financial management provider through the following methods:

• Transactions are audited through selection of a random sample of participants. These audits include a review of records and transactions completed on behalf of participants. The audit methodology uses statistically valid standards to assure that the sample is random and of sufficient size to achieve statistical significance.

• Each financial management service provider is required to ensure the quality of their services through internal quality assurance activities. The Department reviews these activities on a regular basis

• Assessment of participant satisfaction with their financial management provider is obtained as part of regular participant experience surveys.

• Formal assessment of each financial management service provider occurs at least every two (2) years.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Financial Management Services	☐
Residential Habilitation	☐
Supported Employment	☐
Community Support Services	☐
Non-Medical Transportation	☐
Adult Day Health	☐
Skilled Nursing	☐
Home Delivered Meals	☐
Dental Services	☐
Specialized Medical Equipment and Supplies	☐
Personal Emergency Response System	☐
Chore Services	☐
Respite	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Behavior Consultation/Crisis Management	☐
Support Broker Services	☑
Environmental Accessibility Adaptations	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The Department assists participants and legal guardians with this transition and assures that authorization for services under consumer directed services do not expire until new services are in place. The Division of Medicaid provides technical assistance and guidance as requested by participants, support brokers, and circles of support.

Transition from consumer directed services to traditional waiver 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 redetermining the LOC needs, development of a new plan, and review and authorization of the new plan. The participant remains with consumer directed services until this process is completed so that there is no interruption in services.

If at any time there are health and safety issues, the care manager works closely with the participant to ensure that the participant's health and safety is protected. This may include authorizing community crisis supports to address any immediate crises and/or authorizing an emergency 120-day transition plan to assure a smooth transition from consumer directed waiver services to tradtional waiver services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The following requirements must be met or the Department may require the participant to discontinue consumer directed services.

1. Required Supports. The participant is willing to work with a support broker and a fiscal employer agent.

2. Support and Spending Plan. The participant's support and spending plan is being followed.

3. Risk and Safety Back-Up Plans. Back-up plans to manage risks and safety are being followed.

4. Health and Safety Choices. The participant's choices do not directly endanger his health, welfare and safety or endanger or harm others.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		370
Year 2		462
Year 3		490
Year 4		518
Year 5		544

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. 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.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- [x] **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. 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.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- [x] **Recruit staff**
- [ ] **Refer staff to agency for hiring (co-employer)**
- [ ] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The participant and community support worker determines who assumes the above costs.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. **Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**

- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

A calculation tool establishes a budget based on information entered on an Inventory of Individual Needs, an assessment tool designed to capture the participant's functional abilities, behavioral limitations, medical needs and other individual factors related to their developmental disability. The tool is based on a regression analysis model which calculates a budget that correlates with each participant's individualized needs.

The budget tool is periodically evaluated and adjusted to ensure participant budgets are calculated using information that produces the greatest statistical validity when analyzing participant need and cost of services.

To ensure a participant's budget is adequate to meet their individual needs, Idaho provides the following safeguards: 1) When the participant is noticed regarding their budget amount they have the opportunity to appeal that budget within 28 days of the date on the eligibility notice. When the appeal is received it is reviewed by the Department to ensure all the participant's needs were accurately captured through responses on the inventory of individual needs and the participant does not have needs outside of what is captured by the inventory that meet medical necessity criteria. If medically necessary needs not addressed by the inventory are identified, dollars to meet those needs are added to the budget. Individualized budgets will be re-evaluated annually. 2) At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's condition resulting in a need for services that meet medical necessity criteria, and this is not reflected on the current inventory of individual needs. When the Department determines there has been a documented change in condition not reflected on the current inventory, a new inventory is completed and budget calculated for the participant. The participant has the right to appeal this new budget.

The budget setting methodology is identified in IDAPA 16.03.10.514.10 and is also available to anyone submitting a Public Record Request.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

An applicant who selects consumer directed services will be notified of their eligibility for waiver services and given an individual budget through initial or annual ICF/ID Level of Care Eligibility Notice. As outlined in Appendix C-4, a participant who believes their assigned budget is not adequate to meet their assessed needs may appeal by requesting an administrative hearing within 28 days of the date on the notice.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. 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:

The financial management provider must provide a secure file transfer protocol site for the Department to access. This site must have the capability of allowing participants and their employees to access individual specific information such as time cards and account statements. Support brokers are required to assist the participant in monitoring and reviewing their budget.

Budgeted amounts are planned in relation to the participant's needed supports. Community support worker employment agreements submitted to the fiscal employer agent must identify the negotiated rates agreed upon with each community support worker along with the specific support being purchased, the frequency and duration that the support will be provided, and the payment increment; that is, hourly or daily. The fiscal employer agent will compare and match the employment agreements to the appropriate support categories identified on the initial spending plan prior to processing time sheets or invoices for payment.

In addition, the Department authorizes all budgets and support and spending plans. Any changes to approved budget dollars allocated within a support category or the type of support used must be reviewed and authorized by the Department.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Participants are given the opportunity to appeal any Department decision related to waiver eligibility or waiver services. Appeal rights are on all notices including notices for:
• Participants who do not meet ICF/MR Level of Care criteria
• Participants who have been denied services on their Individual Support Plan or Support and Spending Plan
• Eligibility approval notices which include the participant's individualized budgets

Department notices are provided to the participant and guardian in writing and contain information on appealing Department decisions that negatively affect eligibility or services. These notices include information that the participant may request to continue services during the appeal process. Copies of these notices are maintained in the participant file. As stated in IDAPA 16.05.03.101, in order to appeal a decision, a participant must request a Department administrative (fair) hearing within 28 days from the date the notice was mailed.

When a participant requests a Department administrative hearing, an internal review of the participant's file will take place. If through this review additional information is provided, or it is determined that a specific need was inaccurately assessed or missed, Medicaid staff will work with the participant to resolve the appeal prior to hearing. If a settlement is not jointly agreed upon, by the participant and the Department, a hearing will be scheduled.

Participants and the public may learn more about the Department's administrative (fair) hearing processes and policies by accessing the Department of Health & Welfare's website at www.healthandwelfare.idaho.gov, and clicking on the Idaho CareLine 2-1-1 link. The Idaho CareLine website is widely publicized in Idaho and can be accessed directly at www.idahocareline.org. The CareLine provides a detailed description of the Department's administrative hearing process as well as contact information for additional questions.

In addition, participants may receive information on administrative hearings by navigating to the Adult Developmental Disabilities Care Management page. The Adult DD Care Management page provides a list of answers to frequently asked questions including, "What if someone does not like the outcome of the assessment process?" Also, the Consumer Toolkit, distributed by the IAP, describes the participant's right to appeal any Department decision that negatively affects their eligibility or services.

The administrative hearing process is described in Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." In the hearing process, a hearing officer acts as an impartial third party in reviewing Department actions. The Department and the participant each have the opportunity to present his/her case before the hearing officer. The hearing officer considers testimony and evidence presented during hearing along with the pertinent state rules and federal regulations in making a decision.
A written decision is issued by the hearing officer and is sent to the Department and participant. When all administrative remedies are exhausted, the participant may appeal the final decision by requesting a judicial review by the District Court.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

   - (●) **No. This Appendix does not apply**
   - ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Department of Health and Welfare

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The process for addressing complaints is as follows:
1. Upon receipt of a complaint/critical incident, determine if it meets the definition of a complaint/critical incident to be tracked in the complaint/incident reporting application.

2. Enter the details of the complaint/critical Incident in the SharePoint Complaint/Incident Reporting Application. Including the date of the complaint, nature of the complaint, classification, and identifying information.

3. Conduct a search in the reporting application for existing complaints regarding the same provider/participant and include this information in the narrative

4. In the narrative section include details of the investigation, dates and persons interviewed and referrals to appropriate resources that were made. Ensure all components of the Complaint/Incident reporting tool are completed.

5. Include the response resolution date, closure date and outcome.

Issues reported that do not meet the complaint or critical incident reporting definitions, such as provider billing conflicts, will be referred directly to the appropriate MMIS public relations consultant for resolution. However, if the issue is not satisfactorily resolved, Department staff will defer the matter directly to the Division of Medicaid Systems Support Team (MSST), which is responsible to insure provider issues are adequately addressed and resolved.. Issues that may rise to the level of alleged fraud will be referred directly to the Department Program Integrity Unit for further investigation.

The following are the definition of complaints that are expected by the Medicaid Administrator to be tracked through the Complaint/Incident Reporting application.
COMPLAINTS
• Access – Issues involving the availability of services; barriers to obtaining services; or lack of resources/services
• Benefit amount – A disagreement by a participant regarding the amount of benefits that they received. Appeal rights must always be discussed with the participant in a benefit amount investigation
• Confidentiality & Privacy – 1) Privacy – issues dealing with the rights of participants to access and control their health information and not have it used or disclosed by others against their wishes; 2) Confidentiality – not talking about or disclosing personal information regarding a participant of the Department
• Contract services – issues involving an entity providing services under a contract with the Department (Does not include providers of services under Medicaid Provider Agreements)
• DDA Certification Compliance –L&C Field Only
• Denial of service/eligibility – the denial by the Department to provide or reimburse for a service or program requested by a client or his/her representative. Appeal rights must always be discussed with the participant in a denial investigation.
• Discrimination – the prejudicial treatment of individuals protected under federal and/or state law (includes any form of discrimination based on race, color, sex, national origin, age, religion or disability)
• Fraud – an intentional deception or misrepresentation made by a person with knowledge that the deception could

result in some unauthorized benefit to him/herself or some other person IDAPA 16.03.09.201.05
• Referrals – issue or complaint/critical incident dealing with the ability of a provider or participant to obtain a referral to a provider other than the assigned Healthy Connections Primary Care Provider
• Self-Direction Budget Amount – issues that are related to the budget setting process for Self Direction services under the DD waiver
• Quality of Care – issues that involve the meeting or not meeting of rules, policies or commonly accepted practice standards around care/services provided to clients of the Department
• Violation of rights – An intentional or unintentional infringement or transgression against an individual's rights
• Other – When the complaint does not fit one of the classifications listed, this classification may be used, and must describe the complaint/critical incident

Complaints and critical incidents are resolved through thorough investigation which may include referral and collaboration with Adult Protection, Law Enforcement, Medicaid Program Integrity, and other entities. Additionally, investigations may result in provider corrective action and/or appropriate sanction which may include revocation of provider agreement. Additionally, participants are aware that they may exercise their choice of waiver provider at any time.

State laws, regulations, and policies related to this topic include:
- IDAHO CODE TITLE 39
- HEALTH AND SAFETY CHAPTER 53
- ADULT ABUSE, NEGLECT AND EXPLOITATION ACT

Definitions:
• 39-5302. (1) "Abuse" means the intentional or negligent infliction of physical pain, injury or mental injury.
• 39-5302. (8) "Neglect" means failure of a caretaker to provide food, clothing, shelter or medical care reasonably necessary to sustain the life and health of a vulnerable adult, or the failure of a vulnerable adult to provide those services for himself.
• 39-5302. (7) "Exploitation" means an action which may include, but is not limited to, the unjust or improper use of a vulnerable adult's financial power of attorney, funds, property, or resources by another person for profit or advantage.
• 39-5303. Duty to Report: Duty to report cases of abuse, neglect or exploitation of vulnerable adults.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Idaho's "Adult Abuse, Neglect and Exploitation Act" requires that any of the following individuals who have reasonable cause to believe that a vulnerable adult is being or has been abused, neglected or exploited shall immediately report such information to the Idaho commission on aging:
• physician,

• nurse,
• employee of a public or private health facility,
• employee of a state licensed or certified residential facility serving vulnerable adults,
• medical examiner,
• dentist,
• ombudsman for the elderly,
• osteopath,
• optometrist,
• chiropractor,
• podiatrist,
• social worker,
• police officer,
• pharmacist,
• physical therapist, or
• home care worker.

In addition, when there is reasonable cause to believe that abuse or sexual assault has resulted in death or serious physical injury jeopardizing the life, health or safety of a vulnerable adult, any person required to report shall also report such information within four (4) hours to the appropriate law enforcement agency. (Section 39-5303, Idaho Code).

The Department also requires that individuals responsible for monitoring a participant's plan must immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Division of Medicaid, the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law.

Reports to Medicaid may be made by phone, mail, fax, email, or in person. The Department tracks reports and ensures that each complaint or critical incident includes the following information: documentation of incident/complaint, assigned Department Staff and contact information, investigation information, and resolution.

The Department requires reporting for the following types of critical incidents:

Abuse – The intentional or negligent infliction of physical pain, injury or mental injury (Idaho Code 39-5302(1))
Exploitation – An action which may include, but is not limited to, the misuse of a vulnerable person's funds, property, or resources by another person for profit or advantage (Idaho Code, 39-5302(7))
Suspicious death of a participant - A death is labeled as suspicious when either a crime is involved, accident has occurred, the death is not from an expected medical prognosis, a participant dies unexpectedly under care, or when a participant's death occurs because of trauma in a medical setting
Hospitalizations – when a participant is hospitalized as a direct result of an incident by a paid provider (medication error, physical injury, quality of care, neglect, treatment omission, or failure to follow established plans of care)
Injury Caused by Restraints – an injury to a participant is caused by any of the following restraints: 1) Physical restraint is any manual method or physical or manual device, material or equipment attached or adjacent to the participant's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body; 2) Chemical restraint is any drug that is used for discipline or convenience and not required to treat medical symptoms:
-Discipline is defined as any action taken by the provider for the purpose of punishing or penalizing participants
-Convenience is defined as any action taken by the provider to control a participant's behavior or manage a participant's behavior with a lesser amount of effort by the provider and not in the participant's best interest
-Medical symptom is defined as an indication or characteristic of a physical or psychological condition
Medication error - any type of medication related mistake that deviates from the prescription that may negatively impact a participant's health or cause him/her serious injury
Neglect – Failure of a caretaker to provide food, clothing, shelter or medical care reasonably necessary to sustain life and health of a vulnerable adult or child, or the failure of a vulnerable adult to provide those services to him/herself (Idaho Code 39-5302(8))
Child is the victim of a crime – A participant who suffers harm as a direct result of an act committed, or allegedly committed, by another person in the course of a criminal offense. Harm means the participant suffered actual physical harm, mental injury, or the participant's property was deliberately taken, destroyed or damaged
Safety – the participant is placed in a position of danger or risks either intentionally or unintentionally
Serious injury – an injury that requires professional medical treatment, e.g. hospitalizations, fractures, and wounds requiring stitches

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At the time of initial eligibility determination, all participants receive a "Consumer Toolkit." The toolkit contains information on participant rights. It also includes contact information for the Department and advocacy organizations if they have questions about their rights or want to file a complaint related to a violation of rights. The Independent Assessment Provider reviews the toolkit with the participant and other individuals who are at the appointment.

In addition, providers are required to develop, implement and inform participants of written policies to protect and promote the rights of each participant including the right to file complaints and the right to due process.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Investigators with the Idaho Commission on Aging will:
•Determine the nature, extent and cause of the abuse, neglect, or exploitation
•Examine the evidence and consult with persons thought to have knowledge of the circumstances
•Identify, if possible, the person alleged to be responsible for the abuse, neglect or exploitation of the vulnerable adult
•Determine if the allegation is either substantiated or unsubstantiated

A report of abuse, neglect, and/or exploitation of a vulnerable adult by another individual is deemed substantiated when, based upon limited investigation and review, the adult protection worker perceives the report to be credible. A substantiated report shall be referred immediately to law enforcement for further investigation and action. Additionally, the name of the individual against whom a substantiated report was filed shall be forwarded to the Department for further investigation. In substantiated cases of self-neglect, the adult protection worker shall initiate appropriate referrals for supportive services with the consent of the vulnerable adult or his legal representative.

The adult protection worker will close the file if a report of abuse, neglect, and/or exploitation by another individual of a vulnerable adult is not substantiated. If a report is not substantiated, but the adult protection worker determines that the vulnerable adult has unmet service needs, the adult protection worker will initiate appropriate referrals for supportive services with consent of the vulnerable adult or his legal representative.

Reports that come to the Department directly regarding abuse, neglect, or exploitation are referred to the local adult protection agency for further investigation. Complaints not related to abuse, neglect or exploitation are referred to Medicaid. Reports that cannot be immediately resolved by the initial point of contact are assigned a priority level depending on the nature of the report.
1. Priority one indicates that there is an immediate health or safety issue. These reports must be immediately addressed and are typically reported to the adult protection authority and/or law enforcement.
2. Priority two indicates that there is not an immediate health or safety issue. These reports are acted on within ten (10) business days.
3. Priority three indicates that there is some other timeframe requirement outlined in rule or law. In these cases, follow-up is completed within the timeframe outlined in rule or law.

Upon resolving a complaint, the assigned Department staff completes all documentation and notifies appropriate persons. When corrective actions are required, Medicaid Administration will notify Facility Standards, Medicaid Program Integrity unit, and/or the Deputy Attorney General as needed. Statewide compliance with the Department's complaint process and priority timelines are assessed at least quarterly.

The Department ensures that staff adheres to response timelines based on priority level as described in the section "State Critical Event or Incident Reporting Requirements" of this waiver. Review of statewide compliance with priority timelines is assessed at least quarterly during the Bureau Leadership Team meetings. The Bureau Leadership Team consists of the Bureau Chief and the Regional Program Managers. Complaints and critical incidents will be processed in a timely manner, and all written communication must be reviewed by a program supervisor or designee(s) prior to mailing the results to the submitter.

A complaint or critical incident always requires a documented response to the person submitting the

complaint/critical incident. The mode and content of the reply depends on the nature or complexity of the complaint/critical incident. The resolution or status of the investigation must be communicated to the submitter within 10 business days of completing an investigation.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Idaho Commission on Aging is responsible for investigating allegations of abuse, neglect, and exploitation. The Commission contracts with an Area Agency on Aging to complete investigations and is responsible to provide ongoing oversight of these contracts.

The Idaho Commission on Aging meets quarterly with Medicaid and shares information regarding open/ongoing critical incident cases and events. The team discusses interventions taking place, provides status updates and next steps are determined. Idaho Commission on Aging case workers cell phone numbers are made available to Medicaid. If a meeting is needed more frequently than quarterly, then the team has the ability to meet immediately to staff a case.

The Department of Health and Welfare is responsible for all other aspects of critical incidents that affect waiver participants. The status and resolution of each report is available in the complaint/critical incident database. Oversight of the complaint/critical incident process is conducted through a quarterly review by the Bureau of Developmental Disabilities Program Managers and Bureau Chief during Leadership Team Meetings.

The Department requires that providers and other individuals responsible for monitoring the approved plan of service immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Department, the child protection authority, or any other entity identified under Section 16-1605, Idaho Code, or federal law.
Critical Incident Data is collected using the “Complaint and Critical Incident Database” SharePoint. Staff record information about each Critical Incident to include the following:
• Who the Critical Incident was received by
• Date Critical Incident Received
• Expected date of Critical Incident Investigation resolution.
• Program Responsible for Investigating the Critical Incident
• How the Critical Incident is specifically related to Developmental Disability Services to include DD Waiver provider type/specialty
• Staff assigned to conduct the Critical Incident Investigation
• State Region/geographic locale where Critical Incident Occurred.
• Source of the Critical Incident, (who reported the incident to the Department)
• Nature of the Critical Incident, (abuse, neglect, exploitation, serious injury, etc)
• Description of the Critical Incident
• Specific information regarding participant of concern, agency or provider involved, and identifying information regarding the person who submitted the Critical Incident to the Department
• Participant Guardian identifying information, if applicable
• Department Action Taken as a result of the investigation and outcome.
• Whether the critical incident was substantiated or not substantiated.
• Whether Adult Protection and/or Law Enforcement was contacted
• Date Critical Incident was closed.

On a quarterly basis, the Bureau of Developmental Disability Service Quality Manager uploads the SharePoint Critical Incident data to a Spreadsheet for analysis in order to identify trends and patterns. Each January, an annual Complaint and Critical Incident Report is compiled and published by the Quality Manager for the previous year documenting annual trends and patterns and recommending quality improvement strategies to address identified issues and trends.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*:

The State does not permit or prohibits the use of restraints

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

No restraints, other than physical restraint in an emergency, are allowed prior to the use of positive behavior interventions. The following requirements apply to the use of restraints on participants:

•Chemical restraints must not be used unless authorized by an attending physician.

•Mechanical restraints may be used for medical purposes only when authorized by the attending physician. Mechanical restraint for non-medical purposes may be used only when a written behavior change plan is developed by the participant, his service coordinator, his team, and a QIDP or a behavior consultant/crisis management provider as qualified in IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits,” Sections 700 through 706. Informed participant consent is required.

•Physical restraint may be used in an isolated emergency to prevent injury to the participant or others and must be documented in the participant’s record. Physical restraint may be used in a non-emergency setting when a written behavior change plan is developed by the participant, his service coordinator, his team, and a QIDP or a behavior consultant/crisis management provider as qualified in IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits,” Sections 700 through 706. Informed participant consent is required.

•Seclusionary time out may be used only when a written behavior change plan is developed by the participant, his service coordinator, his team, and a QMRP or a behavior consultant/crisis management consultant as qualified in IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits,” Sections 700 through 706. Informed participant consent is required.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of Health and Welfare reviews all plans of service prior to their implementation. When a provider believes the participant may require restraint and/or seclusion to be maintained safely in the community, the plan must outline how:
1. Positive interventions will be used prior to restraint and/or seclusion
2. Restraint and/or seclusion will be used
3. The appropriate authority (as outlined above) has reviewed and approved the use of restraints and/or seclusion

Medicaid assures that these requirements have been met prior to plan authorization. If all of the above requirements have not been met, the proposed plan of services is not authorized.

The use of emergency physical restraints must be documented through a written progress note in the participant’s medical file.

The Department of Health & Welfare reviews the use of restraints and seclusion through regular monitoring of a participant’s health and welfare, provider quality reviews, and oversight of critical incidents.

The Department reviews all complaints received regarding inappropriate use of restraints/seclusion. If

providers are discovered using restraint/seclusion without approval, they are referred to the applicable authority and have appropriate action taken against their certification and/or provider agreement. Depending on the seriousness of the violation, action may be anything from a required plan of correction to termination of provider agreement.

The Department conducts outcome-based reviews on an annual basis. The Department samples a group of waiver participants and performs both a file review and administers a participant experience survey (PES) in person. Through this process the Department discovers areas of concern and will escalate issues to the enhanced review process. Through this process, specific problems are identified and referred to applicable authorities for appropriate action to be taken. This action may be a required plan of correction, termination of the provider agreement or certification, or something in between depending on the seriousness of the violation.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restrictive interventions may only be used when it is documented that they represent the lest-restrictive environment for the participant to live safely and effectively in the community. In addition, positive behavior interventions must be used prior to, and in conjunction with, the implementation of any restrictive intervention.

If a behavior plan utilizes a mechanical restraint for medical purposes or a chemical restraint an attending physician must review and approve, in writing, the plan prior to implementation. If a behavior plan utilizes a mechanical restraint for non-medical purposes, a physical restraint or a seclusionary time out, a QIDP or a behavior consultant/crisis management provider as qualified in IDAPA 16.0310, “Medicaid Enhanced Plan Benefits,” Sections 700 through 706 must review and approve, in writing, the plan prior to implementation.

Personnel involved with supervision and oversight of restraints or seclusion must, at a minimum meet the provider qualifications of QIDP.

Personnel involved in the administration of restraint or seclusion must be trained to meet any health, behavioral or medical requirements of the participants they serve.

A written behavior change plan utilizing mechanical restraints for medical purposes or a chemical restraint must be developed by the participant, legal guardian (if applicable), the person-centered planning team and be authorized by an attending physician. A written behavior change plan utilizing a mechanical restraint for non-medical purposes, a physical restraint or seclusionary time out must be developed by the participant, legal guardian (if applicable), the person-centered planning team, a QIDP or a behavior consultant/crisis management provider as qualified in in IDAPA 16.0310, “Medicaid Enhanced Plan Benefits,” Sections 700 through 706.

When a provider believes the participant may require restraint and/or seclusion to be maintained safely in the community, the plan must outline how:

1) positive interventions will be used prior to restraint and/or seclusion
2) restraint and/or seclusion will be used
3) provide documentation that the appropriate authority (as outlined above) has reviewed and approved the use of restraints and/or seclusion.

Written informed consent is required for all use of restraints.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Health and Welfare reviews all plans of service prior to their implementation. When a provider believes the participant may require a restrictive intervention, the plan must outline how:
1. Positive interventions will be used prior to a restrictive intervention
2. How the intervention will be used
3. The appropriate authority (as outlined above) has reviewed and approved the use of the restrictive intervention.

Medicaid assures that these requirements have been met prior to plan authorization. If all of the above requirements have not been met, the proposed plan of services is not authorized.

Medicaid reviews all complaints received regarding violations of participant rights, including inappropriate use of restrictive interventions. If providers are discovered using restrictive interventions without approval, appropriate action is taken. Substantiated complaints result in action taken against a provider's certification and/or provider agreement. This action is typically a required plan of correction but may be more serious depending on the specific violation and the provider's history.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one)*:

○ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Prior to initial waiver services, and at least annually thereafter, participants must be assessed by their primary care physician on their ability to self-administer medications. Participants who are not capable of self-administration of medications must have their medications administered by an individual licensed in Idaho to administer medications.

Participants who are determined by their physician to be able to self-administer their medications must be further assessed to determine whether or not they require assistance to administer their own medications. This assessment must be completed by a licensed nurse or other qualified professional and must document that the participant:
1. Understands the purpose of the medication.
2. Knows the appropriate dosage and times to take the medication.
3. Understands the expected effects, adverse reactions or side effects, and action to take in an emergency.
4. Is able to take the medication without assistance.

Participants who do not meet all of these requirements may receive assistance with their medications provided:
1. The individual who is assisting is an adult who has successfully completed and follows the approved "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training.
2. The participant's health condition is stable.
3. The participant's health status does not require nursing assessment before receiving the medication nor nursing assessment of the therapeutic or side effects after the medication is taken.
4. The medication is in the original pharmacy-dispensed container with proper label and directions or is an original over-the-counter container or the medication has been place in a unit container by a licensed nurse. Proper measuring devices must be available for liquid medication that is poured from a pharmacy-dispensed container.
5. Written and oral instructions from the licensed physician or other practitioner of the healing arts, pharmacist, or nurse concerning the reason(s) for the medication, the dosage, expected effects, adverse reactions or side effects, and action to take in an emergency have been reviewed by the individual assisting with the participant's medications.
6. Written instructions are in place that outlines required documentation of medication assistance, and whom to call if any doses are not taken, overdoses occur, or actual or potential side effects are observed.
7. Procedures for disposal/destruction of medications must be documented and consistent with procedures outlined in the "Assistance with Medications" course.

The primary care physician specifies the frequency of review of participant medications. This review must occur at least annually. The plan monitor/service coordinator must monitor the plan of service at least every 90 days. This monitoring includes a review of participant medications when warranted by the participant's health status.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful

practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Although the State does not employ the use of a second line monitoring mechanism to oversee the use of behavior modifying medications, it does have processes in place to:
• Routinely monitor a provider's compliance with assisting the participant to take their medications as prescribed.
• Complete a clinical review of plans to ensure formal or informal services or natural supports are in place to provide assistance to the participant (as applicable), when behavior modifying medications have been prescribed by a health care practitioner. This need is verified through a review of a Physician's History and Physical, the Medical, Social and Developmental Assessment, and the Nursing Services and Medication Administration form. Each of these forms is required to be updated and submitted to the Department on an annual basis to be used in the plan review process.
• Investigate any critical incident report received on a participant that relates to health and safety. This includes any concerns related to improper administration or assistance of behavior modifying medications.

Identification of issues or problems with participant medications is accomplished in several ways. These include:

1. Participant medications are listed on the Medical, Social and Developmental Assessment Summary form and are updated annually by the IAP. Any changes to medications or problems with medications over the past year should be identified on this form.

2. Annually, the participant's plan is reviewed by Department staff for authorization. The plan is required to include updates from Provider Status Reviews, and identifies any documented or anticipated health & safety issues.

3. The plan monitor is required to monitor the plan of service at least every ninety (90) days. As outlined in IDAPA 16.03.10.513.05, plan monitoring must include: face-to-face contact with the participant to identify the current status of programs and changes if needed; contact with service providers to identify barriers to service provision; discussion with participant regarding quality and quantity of services.

4. For participants receiving residential habilitation through an agency, the agency is required to review the participants programs (including assistance with medications, if applicable) at least quarterly or more often if required by the participant's condition.

5. For participant's receiving services through a Certified Family Homes (CFH), CFH's are re-certified annually by the Department. The re-certification process includes review of compliance with rules and regulations including handling of and assisting with resident medications.

6. Ongoing waiver provider quality assurance reviews include review of requirements for handling and assisting with participant medications, if applicable. Subsection 705.01, of IDAPA 16.03.10, outlines the requirements for staff assisting with medications.

7. Monitoring of Complaint/Critical Incident Reporting for incidents involving participant medications.

The Department of Health & Welfare is responsible for the follow-up and oversight of potentially harmful medication practices. When these practices are identified through any of the above-listed mechanisms, the Department follows up as appropriate. This follow-up may include requiring changes to the plan of service, referrals to appropriate licensing or certification authorities, and/or provider sanctions.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Idaho Board of Nursing Administrative Rules distinguishes between assistance with medications and administration of medications. These terms are defined in IDAPA 23.01.01, "Rules of the Board of Nursing" as:

Assistance with Medications: The process whereby a non-licensed care provider is delegated tasks by a licensed nurse to aid a patient who cannot independently self-administer medications.

Administration of Medications: The process whereby a prescribed medication is given to a patient by one (1) of several routes. Administration of medication is a complex nursing responsibility which requires knowledge of anatomy, physiology, pathophysiology and pharmacology. Licensed nurses may administer medications and treatments as prescribed by health care providers authorized to prescribe medications.

Only a licensed nurse or other licensed health professionals working within the scope of their license may administer medications. Administration of medications must comply with the Administrative Rules of the Board of Nursing, IDAPA 23.01.01, “Rules of the Idaho Board of Nursing.” Because of this limitation, the only waiver service providers qualified to administer medications are skilled nurses. The requirement for assisting DD waiver participants with medications is outlined in Appendix G-3-b-i.

iii. Medication Error Reporting. *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- ◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

  Providers must maintain a comprehensive medication log that includes any medication errors as defined by the professional licensing board and best practice guidelines.

  Medication administration under the scope of the Nurse Practice Act must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. In Idaho, providers are required to record but not report errors unless requested by the

state. Medication errors may be reviewed if reported to the Department through the Complaint and Critical Incident reporting system. Medication errors include such errors as wrong dose, wrong time, wrong route, wrong medication and missed medication.

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department conducts regular quality assurance reviews of waiver service providers and responds to complaints and reports of critical incidents on an ongoing basis. Quality assurance reviews include checks that nursing providers maintain current licensure and are not subject to any sanctions by the Idaho Board of Nursing.

Providers are required to record but not report medication errors unless requested by the state. Medication errors are be reviewed when reported to the Department through the Complaint and Critical Incident reporting system.

Data related to medication errors is collected if identified as a complaint on the Complaint and Critical Incident Reporting System. If a trend or pattern is identified, the Department's Quality Improvement Specialist will review provider records and discuss complaint and remediation with the provider agency as appropriate, which helps to prevent re-occurrence. Complaints or Critical Incidents beyond the jurisdiction of the Department are referred to the appropriate agency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of service plans that address potential and real risks and back up plans are in place as needed.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: During the survey process, 10% of files are reviewed to ensure service

		plans adequately address the health and welfare of participants
	☑ **Other** Specify: Every 2 years	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of complaints reported by participants or others.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of substantiated complaints

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of critical incidents related to abuse,neglect and exploitation.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of substantiated critical incidents related to abuse, neglect, and exploitation with remediation.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant (and/or family or legal guardian) received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Medicaid BDDS Quality Manager is responsible for QA remediation and system improvement processes and reporting.

The Division of Medicaid's Bureau of Developmental Disability Services, Quality Oversight Committee, (comprised of Quality Manager, BDDS Data Analyst, Quality Team representatives, BDDS Care Manager representatives and BDDS Policy Staff)is responsible for review of data and Annual BDDS LOC Report findings, identification of remediation activities, and monitor of ongoing system improvement initiatives and activities. Recommendations are submitted to BDDS Bureau Chief for consideration.

The Division of Medicaid BDDS Management Team is responsible for identifying and addressing any statewide resource or program issues identified in QA business processes. Reports are analyzed and the result of the analysis is reported to the BDDS Bureau Chief. Recommended program changes or system improvement processes are sent to the Central Office Management Team (COMT) for approval.

Medicaid's Central Office Management Team (COMT)is responsible for reviewing BDDS and other Medicaid program report analyses and recommendations, considering Division wide resources and coordination issues and strategies and making final system wide change decisions

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Division of Medicaid, Bureau of Developmental Disability Services (BDDS) has a Quality Assurance Management Team. This team includes:
• BDDS Bureau Chief
• BDDS Quality Manager
• BDDS HUB Managers
• BDDS Policy Staff
This team is responsible for reviewing Quality Improvement Strategy findings and analysis (including trending), formulating CQI/remediation recommendations, and identifying and addressing any statewide resource or program issues identified in QA business processes.

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.

In addition, the Division of Medicaid, Bureau of Developmental Disability Services has a Self Direction Quality Oversight Committee. This team includes:
• BDDS Quality Manager
• BDDS Data Analyst
• Quality Team representatives
• BDDS Care Manager representatives
• BDDS Policy Staff
This team is responsible for reviewing information related to consumer directed services including data collected from quality assurance processes. The Self Direction Quality Oversight Committee formulates recommendations for program improvement to the Quality Assurance Management Team.

The BDDS Quality Manager is responsible for leading team members and the Quality Assurance tasks for both traditional and consumer directed 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.

ii. System Improvement Activities

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

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

When the Central Office Management Team identifies system wide changes, The BDDS Quality Assurance Management Team monitors and analyzes the effectiveness of the design change.

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

All design changes are tracked through a Continuous Quality Improvement task list. This task list identifies:
• the description of a task
• the implementation plan
• monitoring plan
• outcome

Quality improvement tasks are monitored on a quarterly and annual basis and updates are given to the COMT.

There are several methods the Department uses to communicate policy changes and other important updates

to the public. Information releases (IR) are issued to providers and/or participants to update them on policy, billing, or processing changes. IR's are often sent out to a specific group of providers or participants who may be directly impacted by any changes.

The Department also posts a MedicAide newsletter on the Department of Health and Welfare's website. The MedicAide newsletter is a monthly publication that communicates information to Medicaid providers and other interested parties, and incorporates any IR's that were issued the previous month.

In addition, state law requires that the public receive notification when a state agency initiates proposed rulemaking procedures and be given an opportunity to comment to that rulemaking. Notification of a proposed rulemaking is provided through a Legal Notice that publishes in local newspapers and the Department's website whenever a proposed rulemaking is being published in the Bulletin.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Division of Medicaid's BDDS Quality Manager is responsible for the management and oversight of BDDS's QA system.
These duties include:
• Implementation and monitoring of quality improvement strategy
• Training and oversight of the BDDS Quality Assurance Team
• Related data collection
• Reporting
• Monitoring of unduplicated number of waiver participants on a quarterly basis
• Continuous quality improvement and remediation processes and activities

As part of quarterly monitoring activities, the Quality Manager evaluates the quality improvement strategy for effectiveness and recommends changes as needed.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department must authorize all reimbursable services under the HCBS Waiver Program before the services are rendered.

Prior authorizations for approved services are entered into the Medicaid Management Information System (MMIS) by Medicaid. The prior authorization number must appear on the claim or it will be denied. Approved prior authorizations are valid for one (1) year from the date of prior authorization by Medicaid unless otherwise indicated. Claims are adjudicated by the MMIS in accordance with federal guidelines and Idaho policies. This includes extensive claim edit and audit processing, claim pricing, and claim suspense resolution processing.

The Medical Program Integrity Unit processes support the post-payment analysis of expenditures to identify potential misuse, abuse, quality of care, and treatment outcomes in Medicaid. Functions specifically supported by these processes include the traditional surveillance and utilization review features of the MMIS, retrospective drug utilization review, and outcome-oriented analysis regarding quality of care assessments.

The Department conducts performance monitoring of the MMIS contract to ensure that claims are adjudicated by the MMIS in accordance with federal guidelines and Idaho policies. In addition, Idaho is participating in the Payment Error Rate Measurement (PERM) Program beginning FY 2006.
All records are maintained by the MMIS and are available for review during post-payment audits. These records include: all claims submitted either electronically or on paper, all remittance and status reports which accompany provider payments; and all adjustment request forms.

The State requires the MMIS contractor to contract with, and pay for, an independent certified public accounting firm

to perform an annual audit of the contractor's services to the State in compliance with AICPA Statement on Auditing Standards number 70 (Reports on the Processing of Transactions by Service Organizations).

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
In the aggregate the cost of services on the waiver does not exceed the average cost of ICF/ID services indicated in the most recently submitted 372 report. a. Numerator: Aggregate cost of services on the waiver b. Denominator: Average cost of ICF/ID services indicated in the most recently submitted 372 report

Data Source (Select one):
Other
If 'Other' is selected, specify:
Claims Report

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of demonstrated waiver service provider's fraudulent billing patterns investigated by IDHW and action taken. a. Numerator: Number of demonstrated waiver service provider's fraudulent billing patterns in which action was taken b. Denominator: Number of demonstrated waiver service provider's fraudulent billing patterns investigated by IDHW

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Medicaid's BDDS Quality Manager is responsible for QA remediation and system improvement processes and reporting.

The Division of Medicaid's BDDS Quality Assurance Team is responsible for identifying and addressing any

statewide resource or program issues identified in QA business processes. Reports are analyzed and the result of the analysis is reported to the BDDS Quality Manager. Recommended program changes or system improvement processes are sent to the Medicaid Quality Management Oversight Committee for approval.

The Division of Medicaid, Bureau of Developmental Disability Services, Quality Oversight Committee, (comprised of Quality Manager, BDDS Data Analyst, Quality Team representatives, BDDS Care Manager representatives and BDDS Policy Staff) is responsible for review of data and Annual BDDS LOC Report findings, identification of remediation activities, and monitor of ongoing system improvement initiatives and activities. Recommendations are submitted to BDDS Bureau Chief for consideration.

The Division of Medicaid's BDDS Management Team is responsible for identifying and addressing any statewide resource or program issues identified in QA business processes. Reports are analyzed and the result of the analysis is reported to the BDDS Bureau Chief. Recommended program changes or system improvement processes are sent to the Central Office Management Team (COMT) for approval.

Medicaid's Central Office Management Team (COMT)is responsible for reviewing BDDS and other Medicaid program report analyses and recommendations, considering Division wide resources and coordination issues and strategies and making final system wide change decisions.

The Department of Health & Welfare will use the following strategies to ensure financial oversight with claims and billing:
• MMIS system-level audits are reviewed by contractor personnel to prevent duplicate transactions from being paid more than once, regardless how many times the service is billed. Yearly audit reports are submitted to the Department.
• MMIS ensures that claims are adjudicated by the system in accordance with Federal guidelines and Idaho policies.
• The State requires MMIS to contract with and pay for an independent CPA firm to perform an annual audit of the contractor's services to the State in compliance with AICPA Statement on Auditing Standards number 70 (Reports on the Processing of Transactions by Service Organizations).
• Corrective actions are submitted when appropriate.
• Possible provider fraudulent billing patterns that are identified during the following Quality Improvement processes are investigated and forwarded to the Medicaid Fraud Unit. They are tracked and trended for analysis and provider corrective actions in the Division's Medicaid Complaint/Critical Incident Tracking tool

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

Yes
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

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

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

The Department solicits comments at public hearings when administrative rules related to rate determination methods are promulgated. Administrative rules are published when there are changes to rate determination methods. The public may submit comments on these rules for 21 days after the date of publishing.

Pursuant to 42 CFR § 447.205, the Department gives notice of its proposed reimbursement changes by publishing legal notices throughout the State to inform providers about any change. Additionally, payment rates are published on our website at www.healthandwelfare.idaho.gov for participants to access.

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

Please see below for services and Reimbursement Methodology information:

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

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

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

Dental Services:
The rate paid for dental services is a negotiated, per member per month payment. It is paid to the dental contractor for each waiver participant age 21 or older.

Environmental Accessibility Adaptations:
These items are manually priced based on the submitted invoice price.

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

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

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

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

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

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

Specialized Medical Equipment and Supplies:
These items are manually priced based on the submitted invoice price.

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

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

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

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

For participants selecting traditional waiver services, provider billing flows directly from the provider to the State's claim payment MMIS system.

For participants who select consumer directed services, use a Fiscal Employer Agent to process provider billing. The Fiscal Employer Agent pays claims that have been approved on the Support and Spending Plan and then bills through MMIS.

Appendix I: Financial Accountability

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

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

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

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All Medicaid claims for waiver services are processed through the State's Medicaid Management Information System (MMIS). The MMIS is managed and monitored through the Division of Medicaid.

Participant's financial eligibility is determined by the Division of Welfare. Once eligibility is determined, the participant's information and eligibility is electronically transmitted to the MMIS from the State's Idaho Benefits Eligibility System (IBES). Claims are edited against the eligibility file in the MMIS to ensure that claims are paid for Medicaid eligible participants only.

Prior authorization of Medicaid reimbursable services on the approved service plan is entered into the MMIS by the Division of Medicaid.

Explanation of Medicaid Benefits are generated monthly and sent to a sampling of participants receiving services to verify that the services were provided. The sample size of participants that receive an Explanation of Benefits notice is 1% of the eligible participants that had paid claims in the past month.

The Department's Program Integrity Unit opens two to three cases per month based on participant responses to this auditing process. In addition, the Program Integrity Unit uses a utilization review system that categorizes all providers by type and specialty, ranks them in categories, and does a peer grouping analysis comparing provider

billing patterns against their peers. It ranks the most probable abusive patterns from most to least abusive. Providers with probable abusive billing patterns receive further analysis by Program Integrity Unit staff and follow-up reviews are initiated when warranted.

Finally, during retrospective quality assurance reviews, Department staff review participant progress notes and documentation of services. When staff discover inadequate documentation or inconsistent service delivery, they make a referral to the Program Integrity Unit for further investigation.

All records are maintained by the MMIS and are available for review during post-payment audits. These records include: all claims submitted either electronically or on paper, all remittance and status reports which accompany provider payments; and all adjustment request forms.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Consumer directed services are paid through a qualified financial management service provider chosen by the participant. The provider bills Medicaid through the MMIS according to the participant's plan which is prior authorized by the Department. The financial management service provider maintains records for each participant. These records indicate spending within the following categories:
1. Support Broker Services
2. Community Support Services
a. Job Support
b. Personal Support
c. Relationship Support
d. Emotional Support
e. Learning Support
f. Transportation Support
g. Adaptive Equipment
h. Skilled Nursing

The Department enters into a provider agreement with qualified providers to perform Financial Management Services for participants who select consumer directed services. The Department monitors the activities of each financial management provider through the following methods:

• Transactions are audited through selection of a random sample of participants. These audits include a review of records and transactions completed on behalf of participants. The audit methodology uses statistically valid standards to assure that the sample is random and of sufficient size to achieve statistical significance.

• Each financial management service provider is required to ensure the quality of their services through internal quality assurance activities. The Department reviews these activities on a regular basis

• Assessment of participant satisfaction with their financial management provider is obtained as part of regular participant experience surveys.

• Formal assessment of each financial management service provider occurs at least every two (2) years.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I -3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of**

the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement

(indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
○ **The following source(s) are used**
Check each that applies:
☐ **Health care-related taxes or fees**
☐ **Provider-related donations**
☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The following is the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

1. As indicated in the rate determination method, payment for room and board in residential settings is not used to derive the Medicaid rate. The room and board allowance in a residential setting is the responsibility of the participant (and/or family or legal representative as appropriate) and is paid to the provider directly on a monthly basis.

Residential settings must provide room, utilities and three daily meals (room and board) to the resident. The charge for room and board must be established in the residential setting's admission agreement. As outlined in 16.03.19.260, at the time of admission, the provider and the resident must enter into an admission agreement. The agreement must be in writing and be signed by both parties. The agreement must, in itself or by reference to the

resident's plan of care, include the amount the home will charge for room and board. The participant's plan of care, including admission records, must be authorized by the Department prior to admission.

2. The room and board allowance is not used to determine eligibility for Medicaid. It is not used to determine eligibility for the basic monthly allowance or the amount of the basic monthly allowance. Further, the room and board allowance is not the basic needs allowance used to calculate/figure client participation.

As of January 1, 2012, the budgeted room and board allowance is six hundred ninety-three dollars ($693). The Room and Board allowance will be adjusted annually by eighty percent (80%) of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The room and board allowance increase will be rounded up to the next dollar

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ( ) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- (●) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [x] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I -7-a-iii and the groups for whom such charges are excluded.

Only participants who qualify under 42 CFR 435.217 are required to pay a co-payment.

Idaho Native American Indians who are accessing care from Indian Health facilities or show they are eligible and referred through contract health services are exempted from cost sharing requirements

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge
Residential Habilitation	**Amount:** Calculated Rate Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form of co-payments per IDAPA 16.03.18 **Basis:** Based on units and costs of services used per month.
Respite	**Amount:** Calculated Rate Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form of co-payments per IDAPA 16.03.18 **Basis:** Based on units and costs of services used per month.
Supported Employment	**Amount:** Calculated Rate Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form of co-payments per IDAPA 16.03.18

Waiver Service	Charge
	Basis: Based on units and costs of services used per month.
Community Support Services	**Amount:** Calculated Rate Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form of co-payments per IDAPA 16.03.18 **Basis:** Based on units and costs of services used per month.
Support Broker Services	**Amount:** Calculated Rate Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form of co-payments per IDAPA 16.03.18 **Basis:** Based on units and costs of services used per month.
Adult Day Health	**Amount:** Calculated Rate Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form of co-payments per IDAPA 16.03.18 **Basis:** Based on units and costs of services used per month.
Behavior Consultation/Crisis Management	**Amount:** Calculated Rate Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form of co-payments per IDAPA 16.03.18 **Basis:** Based on units and costs of services used per month.
Chore Services	**Amount:** Calculated Rate Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form of co-payments per IDAPA 16.03.18 **Basis:** Based on units and costs of services used per month.
Home Delivered Meals	**Amount:** Calculated Rate Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form of co-payments per IDAPA 16.03.18 **Basis:**

Waiver Service	Charge
	Based on units and costs of services used per month.
Personal Emergency Response System	**Amount:** Calculated Rate Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form of co-payments per IDAPA 16.03.18 **Basis:** Based on units and costs of services used per month.
Skilled Nursing	**Amount:** Calculated Rate Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form of co-payments per IDAPA 16.03.18 **Basis:** Based on units and costs of services used per month.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

- (●) **There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**
- ( ) **There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**

Specify the cumulative maximum and the time period to which the maximum applies:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the

groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	26850.81	16295.00	43145.81	90797.00	8033.00	98830.00	55684.19
2	35122.65	17303.00	52425.65	92871.00	8305.00	101176.00	48750.35
3	36903.66	18169.00	55072.66	94946.00	8578.00	103524.00	48451.34
4	38770.89	19077.00	57847.89	97021.00	8850.00	105871.00	48023.11
5	40722.59	20031.00	60753.59	99095.00	9122.00	108217.00	47463.41

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B -3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	3196	3196	
Year 2	3709	3709	
Year 3	3935	3935	
Year 4	4159	4159	
Year 5	4371	4371	

Appendix J: Cost Neutrality Demonstration

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

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

To estimate the average waiver length of stay, the DD waiver CMS-372 reports for the previous three years were used. Days are limited to 365.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Historical waiver expenditure data and user data from the 372 reports was used to assist in projecting forward the estimate for the five-year waiver period.

The estimated number of users of each service (except for dental services) was calculated by reviewing the number of users of each service on the 372 report, and increasing that number at the same rate that the overall number of waiver participants is expected to increase during the five-year waiver period. Of all waiver participants, 85% were projected to be in the age range which will receive dental services through the waiver (21 years of age and older).

The 372 reports and DD Procedure Code Price List were used to derive the number of units per user. Estimated units per user were held constant through the five years of the waiver renewal.

The starting cost per unit was generally derived from the DD Procedure Code Price list. The dental services cost per unit was based on a per member per month rate for the waiver dental contract. The cost per unit was projected to increase each year based on estimates derived from the internal MMIS system.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Historical Medicaid expenditures for DD waiver participants from the internal MMIS system were reviewed and projected forward over the five year estimate period, based on the historical trend.

The state did not include the cost of prescribed drugs furnished to Medicare/Medicaid dual eligibles under the provision of Part D when estimating D'.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates were derived from actual data available in the internal MMIS system and then projected forward over the five year estimate period, based on the historical trend.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Estimates were derived from actual data available in the internal MMIS system and then projected forward over the five year estimate period, based on the historical trend.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Residential Habilitation	
Respite	
Supported Employment	
Community Support Services	
Financial Management Services	
Support Broker Services	
Adult Day Health	

Waiver Services	
Behavior Consultation/Crisis Management	
Chore Services	
Dental Services	
Environmental Accessibility Adaptations	
Home Delivered Meals	
Non-Medical Transportation	
Personal Emergency Response System	
Skilled Nursing	
Specialized Medical Equipment and Supplies	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**63943061.04**
Residential Habilitation	15 minute	2049	8766.00	3.56	**63943061.04**	
Respite Total:						**20638.16**
Respite	15 minute	4	2411.00	2.14	**20638.16**	
Supported Employment Total:						**1671993.20**
Supported Employment	15 minute	284	1130.00	5.21	**1671993.20**	
Community Support Services Total:						**14754386.40**
Community Support Services	Per week	370	52.00	766.86	**14754386.40**	
Financial Management Services Total:						**404003.00**
Financial Management Services	Per member per mon	370	10.00	109.19	**404003.00**	
Support Broker Services Total:						**371021.20**
Support Broker Services	15 minute	370	212.00	4.73	**371021.20**	
Adult Day Health Total:						**2937004.80**
GRAND TOTAL:						**85815186.32**
Total Estimated Unduplicated Participants:						**3196**
Factor D (Divide total by number of participants):						**26850.81**
Average Length of Stay on the Waiver:						345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health	15 minute	1328	1455.00	1.52	2937004.80	
Behavior Consultation/Crisis Management Total:						532332.00
Behavior Consultation/Crisis Management	15 minute	159	432.00	7.75	532332.00	
Chore Services Total:						376.09
Chore Services	Per Chore	1	1.00	376.09	376.09	
Dental Services Total:						449159.04
Dental Services	Per member per mon	2448	12.00	15.29	449159.04	
Environmental Accessibility Adaptations Total:						6651.37
Environmental Accessibility Adaptations	Per adaptation	1	1.00	6651.37	6651.37	
Home Delivered Meals Total:						111291.02
Home Delivered Meals	Meal	67	314.00	5.29	111291.02	
Non-Medical Transportation Total:						370920.00
Non-Medical Transportation	Mile	300	2810.00	0.44	370920.00	
Personal Emergency Response System Total:						4314.00
Personal Emergency Response System	Month	15	5.00	57.52	4314.00	
Skilled Nursing Total:						223777.80
Skilled Nursing	15 minute	340	103.00	6.39	223777.80	
Specialized Medical Equipment and Supplies Total:						14257.20
Specialized Medical Equipment and Supplies	Piece of equipment	30	1.00	475.24	14257.20	
GRAND TOTAL:						85815186.32
Total Estimated Unduplicated Participants:						3196
Factor D (Divide total by number of participants):						26850.81
Average Length of Stay on the Waiver:						345

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and

Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**105013997.84**
Residential Habilitation	15 minute	2722	10837.00	3.56	**105013997.84**	
Respite Total:						**14320.88**
Respite	15 minute	7	956.00	2.14	**14320.88**	
Supported Employment Total:						**1059182.58**
Supported Employment	15 minute	186	1093.00	5.21	**1059182.58**	
Community Support Services Total:						**18128029.92**
Community Support Services	Per week	462	52.00	754.58	**18128029.92**	
Financial Management Services Total:						**498960.00**
Financial Management Services	Per member per mon	462	10.00	108.00	**498960.00**	
Support Broker Services Total:						**458377.92**
Support Broker Services	15 minute	462	212.00	4.68	**458377.92**	
Adult Day Health Total:						**3744261.60**
Adult Day Health	15 minute	1570	1569.00	1.52	**3744261.60**	
Behavior Consultation/Crisis Management Total:						**286734.50**
Behavior Consultation/Crisis Management	15 minute	26	1423.00	7.75	**286734.50**	
Chore Services Total:						**376.09**
Chore Services	Per chore	1	1.00	376.09	**376.09**	
Dental Services Total:						**525979.80**
Dental Services	Per member per mon	2837	12.00	15.45	**525979.80**	
Environmental Accessibility Adaptations Total:						**39908.22**
Environmental Accessibility Adaptations	Adaptation	6	1.00	6651.37	**39908.22**	
				GRAND TOTAL:		**130269904.64**
				Total Estimated Unduplicated Participants:		**3709**
				Factor D (Divide total by number of participants):		**35122.65**
				Average Length of Stay on the Waiver:		345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals Total:						**62051.70**
Home Delivered Meals	Meal	46	255.00	5.29	**62051.70**	
Non-Medical Transportation Total:						**169185.72**
Non-Medical Transportation	Mile	201	1913.00	0.44	**169185.72**	
Personal Emergency Response System Total:						**1607.68**
Personal Emergency Response System	Month	5	5.59	57.52	**1607.68**	
Skilled Nursing Total:						**232730.19**
Skilled Nursing	15 minute	301	121.00	6.39	**232730.19**	
Specialized Medical Equipment and Supplies Total:						**34200.00**
Specialized Medical Equipment and Supplies	Piece of equipment	24	3.00	475.00	**34200.00**	
				GRAND TOTAL:		**130269904.64**
				Total Estimated Unduplicated Participants:		**3709**
				Factor D (Divide total by number of participants):		**35122.65**
				Average Length of Stay on the Waiver:		345

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

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

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**117051737.44**
Residential Habilitation	15 minute	2888	10837.00	3.74	**117051737.44**	
Respite Total:						**15057.00**
Respite	15 minute	7	956.00	2.25	**15057.00**	
Supported Employment Total:						**1177805.87**
				GRAND TOTAL:		**145215918.59**
				Total Estimated Unduplicated Participants:		**3935**
				Factor D (Divide total by number of participants):		**36903.66**
				Average Length of Stay on the Waiver:		345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment	15 minute	197	1093.00	5.47	1177805.87	
Community Support Services Total:						20290233.60
Community Support Services	Per week	490	52.00	796.32	20290233.60	
Financial Management Services Total:						529200.00
Financial Management Services	Per member per mon	490	10.00	108.00	529200.00	
Support Broker Services Total:						486158.40
Support Broker Services	15 minute	490	212.00	4.68	486158.40	
Adult Day Health Total:						4182326.40
Adult Day Health	15 minute	1666	1569.00	1.60	4182326.40	
Behavior Consultation/Crisis Management Total:						324330.16
Behavior Consultation/Crisis Management	15 minute	28	1423.00	8.14	324330.16	
Chore Services Total:						394.89
Chore Services	Chore	1	1.00	394.89	394.89	
Dental Services Total:						564194.40
Dental Services	Per member per mon	3010	12.00	15.62	564194.40	
Environmental Accessibility Adaptations Total:						41903.64
Environmental Accessibility Adaptations	Adaptation	6	1.00	6983.94	41903.64	
Home Delivered Meals Total:						69347.25
Home Delivered Meals	Meal	49	255.00	5.55	69347.25	
Non-Medical Transportation Total:						187435.74
Non-Medical Transportation	Mile	213	1913.00	0.46	187435.74	
Personal Emergency Response System Total:						1510.00
Personal Emergency Response System	Month	5	5.00	60.40	1510.00	
Skilled Nursing Total:						256858.80

GRAND TOTAL:	145215918.59
Total Estimated Unduplicated Participants:	3935
Factor D (Divide total by number of participants):	36903.66
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled Nursing	15 minute	319	120.00	6.71	256858.80	
Specialized Medical Equipment and Supplies Total:						37425.00
Specialized Medical Equipment and Supplies	Piece of equipment	25	3.00	499.00	37425.00	
				GRAND TOTAL:		145215918.59
				Total Estimated Unduplicated Participants:		3935
				Factor D (Divide total by number of participants):		36903.66
				Average Length of Stay on the Waiver:		345

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						130025468.73
Residential Habilitation	15 minute	3053	10837.00	3.93	130025468.73	
Respite Total:						15793.12
Respite	15 minute	7	956.00	2.36	15793.12	
Supported Employment Total:						1304954.56
Supported Employment	15 minute	208	1093.00	5.74	1304954.56	
Community Support Services Total:						22575869.68
Community Support Services	Per week	518	52.00	838.13	22575869.68	
Financial Management Services Total:						559440.00
Financial Management Services	Per member per mon	518	10.00	108.00	559440.00	
Support Broker Services Total:						513938.88
Support Broker Services	15 minute	518	212.00	4.68	513938.88	
				GRAND TOTAL:		161248141.26
				Total Estimated Unduplicated Participants:		4159
				Factor D (Divide total by number of participants):		38770.89
				Average Length of Stay on the Waiver:		345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**4641855.12**
Adult Day Health	15 minute	1761	1569.00	1.68	**4641855.12**	
Behavior Consultation/Crisis Management Total:						**364999.50**
Behavior Consultation/Crisis Management	15 minute	30	1423.00	8.55	**364999.50**	
Chore Services Total:						**414.63**
Chore Services	Chore	1	1.00	414.63	**414.63**	
Dental Services Total:						**589942.80**
Dental Services	Per member per mon	3182	12.00	15.45	**589942.80**	
Environmental Accessibility Adaptations Total:						**43998.84**
Environmental Accessibility Adaptations	Adaptation	6	1.00	7333.14	**43998.84**	
Home Delivered Meals Total:						**77305.80**
Home Delivered Meals	Meal	52	255.00	5.83	**77305.80**	
Non-Medical Transportation Total:						**206604.00**
Non-Medical Transportation	Mile	225	1913.00	0.48	**206604.00**	
Personal Emergency Response System Total:						**1585.50**
Personal Emergency Response System	Month	5	5.00	63.42	**1585.50**	
Skilled Nursing Total:						**285102.00**
Skilled Nursing	15 minute	337	120.00	7.05	**285102.00**	
Specialized Medical Equipment and Supplies Total:						**40868.10**
Specialized Medical Equipment and Supplies	Piece of equipment	26	3.00	523.95	**40868.10**	
			GRAND TOTAL:			**161248141.26**
			Total Estimated Unduplicated Participants:			**4159**
			Factor D (Divide total by number of participants):			**38770.89**
			Average Length of Stay on the Waiver:			345

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

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

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						**143624603.29**
Residential Habilitation	15 minute	3209	10837.00	4.13	**143624603.29**	
Respite Total:						**16596.16**
Respite	15 minute	7	956.00	2.48	**16596.16**	
Supported Employment Total:						**1443383.01**
Supported Employment	15 minute	219	1093.00	6.03	**1443383.01**	
Community Support Services Total:						**24950581.76**
Community Support Services	Per week	544	52.00	882.02	**24950581.76**	
Financial Management Services Total:						**587520.00**
Financial Management Services	Per member per mon	544	10.00	108.00	**587520.00**	
Support Broker Services Total:						**516669.44**
Support Broker Services	15 minute	544	212.00	4.48	**516669.44**	
Adult Day Health Total:						**5111425.44**
Adult Day Health	15 minute	1851	1569.00	1.76	**5111425.44**	
Behavior Consultation/Crisis Management Total:						**408913.28**
Behavior Consultation/Crisis Management	15 minute	32	1423.00	8.98	**408913.28**	
Chore Services Total:						**435.36**
Chore Services	Per chore	1	1.00	435.36	**435.36**	
Dental Services Total:						**619977.60**
Dental Services	Per member per mon	3344	12.00	15.45	**619977.60**	
Environmental Accessibility Adaptations Total:						**46194.00**
				GRAND TOTAL:		**177998445.24**
				Total Estimated Unduplicated Participants:		**4371**
				Factor D (Divide total by number of participants):		**40722.59**
				Average Length of Stay on the Waiver:		345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations	Adaptation	6	1.00	7699.00	**46194.00**	
Home Delivered Meals Total:						**85833.00**
Home Delivered Meals	Meal	55	255.00	6.12	**85833.00**	
Non-Medical Transportation Total:						**225734.00**
Non-Medical Transportation	Mile	236	1913.00	0.50	**225734.00**	
Personal Emergency Response System Total:						**1664.75**
Personal Emergency Response System	Month	5	5.00	66.59	**1664.75**	
Skilled Nursing Total:						**314352.00**
Skilled Nursing	Hour	354	120.00	7.40	**314352.00**	
Specialized Medical Equipment and Supplies Total:						**44562.15**
Specialized Medical Equipment and Supplies	Piece of equipment	27	3.00	550.15	**44562.15**	

GRAND TOTAL:	**177998445.24**
Total Estimated Unduplicated Participants:	**4371**
Factor D (Divide total by number of participants):	**40722.59**
Average Length of Stay on the Waiver:	345