

(ONLY THOSE SECTIONS WITH AMENDMENTS ARE SHOWN.)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Agencies must verify that individuals working in the area listed in Subsection 009.03 of these rules whom are employed or whom they contract have complied with the provisions in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." (3-19-07)

02. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (3-19-07)

03. Providers Subject to Criminal History and Background Check Requirements. The following providers are required to have a criminal history and background check: (3-19-07)

a. Adult Day Health Providers. The criminal history and background check requirements applicable to providers of adult day health as provided in Sections 329 and 705 of these rules. (4-4-13)

b. Adult Residential Care Providers. The criminal history and background check requirements applicable to adult residential care providers as provided in Section 329 of these rules. (4-2-08)

c. Attendant Care Providers. The criminal history and background check requirements applicable to attendant care providers as provided in Section 329 of these rules. (4-2-08)

d. Behavior Consultation or Crisis Management Providers. The criminal history and background check requirements applicable to behavior consultation or crisis management providers as provided in Section 705 of these rules. (4-4-13)

e. Certified Family Home Providers and All Adults in the Home. The criminal history and background check requirements applicable to certified family homes are found in Sections 305, 329 and 705 of these rules, and as provided in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (4-2-08)

f. Chore Services Providers. The criminal history and background check requirements applicable to chore services providers as provided in Sections 329 and 705 of these rules. (4-2-08)

~~**g. Crisis Intervention Providers.** The criminal history and background check requirements applicable to crisis intervention providers as provided in Section 685 of these rules. (7-1-11)~~

~~**h. Companion Services Providers.** The criminal history and background check requirements applicable to companion services providers as provided in Section 329 of these rules. (4-2-08)~~

~~**i. Day Habilitation Providers.** The criminal history and background check requirements applicable to day habilitation providers as provided in Section 329 of these rules. (4-4-13)~~

~~**j. Developmental Disabilities Agencies (DDA).** The criminal history and background check for DDA and staff as provided in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 009. (7-1-11)~~

~~**k. Homemaker Services Providers.** The criminal history and background check requirements applicable to homemaker services providers as provided in Section 329 of these rules. (4-2-08)~~

~~**l. Personal Assistance Agencies Acting As Fiscal Intermediaries.** The criminal history and~~

background check requirements applicable to the staff of personal assistance agencies acting as fiscal intermediaries as provided in Subsection 329.02 of these rules. (3-19-07)

m. Personal Care Providers. The criminal history and background check requirements applicable to personal care providers as provided in Subsection 305.06 of these rules. (3-19-07)

n. Residential Habilitation Providers. The criminal history and background check requirements applicable to residential habilitation providers as provided in Sections 329 and 705 of these rules, and IDAPA 16.04.17 "Rules Governing Residential Habilitation Agencies," Sections 202 and 301. (4-2-08)

o. Respite Care Providers. The criminal history and background check requirements applicable to respite care providers as provided in Sections 329, 665, and 705 of these rules. (7-1-11)

p. Service Coordinators and Paraprofessionals. The criminal history and background check requirements applicable to service coordinators and paraprofessionals working for an agency as provided in Section 729 of these rules. (3-19-07)

q. Skilled Nursing Providers. The criminal history and background check requirements applicable to skilled nursing providers as provided in Sections 329 and 705 of these rules. (4-4-13)

r. Supported Employment Providers. The criminal history and background check requirements applicable to supported employment providers as provided in Sections 329 and 705 of these rules. (4-2-08)

s. Therapeutic Consultant. The criminal history and background check requirements applicable to therapeutic consultation providers as provided in Section 685 of these rules. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

038. GENERAL REIMBURSEMENT: TYPES OF PARTICIPANT SERVICES.
The following types of services are reimbursed as provided in Section 037 of these rules. (4-4-13)

01. Personal Care Services. The fees for personal Care Services (PCS) described in Section 300 of these rules. (4-4-13)

02. Aged and Disabled Waiver Services. The fees for personal care services (PCS) described in Section 320 of these rules. (4-4-13)

03. ~~Children's Waiver Services~~ Children's Developmental Disabilities (DD) Home and Community-Based Services (HCBS) State Plan Option. ~~The fees for children's waiver services described in Section 680 of these rules~~ The fees for Children's DD HCBS state plan option described in Section 520 of these rules. ~~(4-4-13)~~ (7-1-19)T

04. Adults with Developmental Disabilities Waiver Services. The fees for adults with developmental disabilities waiver services described in Section 700 of these rules. (4-4-13)

05. Service Coordination. The fees for service coordination described in Section 720 of these rules. (4-4-13)

06. Therapy Services. The fees for physical therapy, occupational therapy, and speech-language pathology services described in Section 215 of these rules include the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the client for the use of such equipment. (4-4-13)

(BREAK IN CONTINUITY OF SECTIONS)

SUB-PART: ~~CHILDREN'S DEVELOPMENTAL DISABILITIES PRIOR AUTHORIZATION~~ CHILDREN'S DEVELOPMENTAL DISABILITIES (DD) HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN OPTION
(Sections 520 - 528)

520. ~~CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA)~~ CHILDREN'S DD HCBS STATE PLAN OPTION.

~~The purpose of the children's DD Prior Authorization is to ensure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self determination, and independence. Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of service, prior approval of services, and a quality improvement program. Prior authorization is intended to help ensure the provision of necessary and appropriate services and supports. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for HCBS as described in Section 310 through 317 of these rules, and for the specific services included on the plan. Delivery of each service identified on the plan of service cannot be initiated until after the plan has been signed by the provider agency professional responsible for service provision~~ In accordance with Section 1915(i) of the Social Security Act, the Department will pay for home and community-based services provided by individuals or agencies that have entered into a provider agreement with the Department. (7-1-16)(7-1-19)T

521. ~~CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): DEFINITIONS~~ CHILDREN'S DD HCBS STATE PLAN OPTION: DEFINITIONS.

For the purposes of Sections 520 through 528 of these rules, the following terms are used as defined below (7-1-11)(7-1-19)T

~~01. **Assessment.** A process that is described in Section 522 of these rules for program eligibility and in Section 526 of these rules for plan of service.~~ (7-1-11)

~~021. **Baseline Annual.** A participant's skill level prior to intervention written in measurable, behaviorally-stated terms~~ Every three hundred sixty-five (365) days, except during a leap year which equals three hundred sixty-six (366) days. (7-1-11)(7-1-19)T

~~032. **Child Community.** A person who is under the age of eighteen (18) years~~ Natural, integrated environments outside of the home, school, or DDA center based settings. (7-1-11)(7-1-19)T

~~043. **Family Developmental Disabilities Agency (DDA).** The participant and his parent(s) or legal guardian~~ (7-1-11)(7-1-19)T

~~a. A type of developmental disabilities facility, as defined in Section 39-4604, Idaho Code, that is non-residential and provides services on an outpatient basis;~~ (7-1-19)T

~~b. Certified by the Department to provide services to participants with developmental disabilities; and~~ (7-1-19)T

~~c. A business entity, open for business to the general public.~~ (7-1-19)T

05. Family-Centered Planning Process. A participant-focused planning process directed by the participant or the participant's decision-making authority and facilitated by the paid or non-paid plan developer. The family-centered planning team discusses the participant's strengths, needs, and preferences, including the participant's safety and the safety of those around the participant. This discussion helps the participant or the participant's decision-making authority make informed choices about the services and supports included on the plan of service. (7-1-11)

06. Family-Centered Planning Team. The planning group who helps inform the participant about

available services ~~and supports~~ in order to develop the participant's plan of service. This group includes, at a minimum, the ~~child~~ participant, the participant's decision-making authority, and the plan developer. If the participant is unable to attend the family-centered planning (FCP) meeting, the Plan of Service must contain documentation to justify the participant's absence. The family-centered planning team must include people chosen by the participant and the family, or agreed upon by the participant and the family as important to the process. (7-1-16)(7-1-19)T

07. ~~ICF/IID~~ **Home and Community-Based Services State (HCBS) Plan Option.** ~~Intermediate care facility for persons with intellectual disabilities~~ The federal authority under Section 1915(i) of the Social Security Act that allows a state to provide through a state plan amendment, medical assistance for home and community-based services for elderly and participants with disabilities, without determining that without the provision of services the participants would require institutional level of care. (7-1-16)(7-1-19)T

08. ~~Individualized Family Service Plan (IFSP)~~ **Integration.** ~~An initial or annual plan of service for providing early intervention services to children from birth to three (3) years of age (thirty six (36) months old). The plan is developed by the family-centered planning team that includes the child participant, the participant's decision-making authority and other planning team members chosen by the participant's decision-making authority, and the Department or its designee. The IFSP must meet the provisions of the Individuals with Disabilities Education Act (IDEA), Part C, and must be developed in accordance with Sections 316 through 317 of these rules. The IFSP may serve as the plan of service if it meets all of the components of the plan of service. The IFSP may also serve as a program implementation plan~~ The process of promoting a lifestyle for participants with developmental disabilities that is as much as possible like that of other citizens of the community, including living in the community and having access to community resources. A further goal of this process is to enhance the social image and personal competence of participants with developmental disabilities. (7-1-16)(7-1-19)T

09. **Level of Support.** The amount of services and supports necessary to allow the ~~individual~~ participant to live independently and safely in the community. (7-1-16)(7-1-19)T

10. **Medical, Social, and Developmental Assessment Summary.** A form used by the Department ~~or its contractor~~ to gather a participant's medical, social and developmental history and other summary information. It is required for all participant's receiving home and community-based services under a plan of service. The information is used in the assessment and authorization of a participant's services. (7-1-16)(7-1-19)T

11. **Plan Developer.** A paid or non-paid person who, under the direction of the participant or the participant's decision-making authority, is responsible for developing a single plan of service and subsequent addenda. The ~~plan of~~ service plan must ~~that~~ cover all services and supports identified during the family-centered planning process and must meet the HCBS person-centered plan requirements as described in Section 317 of these rules. (7-1-16)(7-1-19)T

12. **Plan Monitor.** A person who oversees the provision of services on a paid or non-paid basis and is identified on the participant's person-centered plan of service. (7-1-16)(7-1-19)T

13. **Plan of Service.** An initial or annual plan of service, developed by the participant, the participant's decision-making authority, and the family-centered planning team, that identifies all services ~~and supports~~ that were determined through a family-centered planning process. The plan development is required in order to provide DD services to children from birth through seventeen (17) years of age. This plan must be developed in accordance with Sections 316 and 317 of these rules. (7-1-16)(7-1-19)T

14. **Practitioner of the Healing Arts, Licensed.** A licensed physician, physician assistant, or nurse practitioner. (7-1-11)

15. **Prior Authorization (PA).** A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as ~~provided by~~ described in Sections 520 ~~and~~ through 528 ~~of~~ these rules. (7-1-16)(7-1-19)T

16. **Provider Status Review.** The written documentation that identifies the participant's progress toward goals defined in the plan of service, and demonstrates the continued need for the service. (7-1-11)

17. **Right Care.** Accepted treatment for defined diagnosis, functional needs and abilities to achieve the

desired outcome. The right care is consistent with best practice and continuous quality improvement. (7-1-11)

18. Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (7-1-11)

19. Right Price. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the participant's needs for services and supports as identified in the assessment. (7-1-11)

20. Right Outcomes. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (7-1-11)

21. ~~Services~~ Supervisor. ~~Evaluation, diagnostic, therapy, training, assistance, and support services that are provided to persons with developmental disabilities~~ For the purposes of these rules, the supervisor is the individual responsible for the supervision of DDA staff as outlined in IDAPA 16.03.09, "Children's Habilitation Intervention Services."- (7-1-11)(7-1-19)T

22. Support Services. Services that provide supervision and assistance to a participant or facilitates integration into the community. (7-1-19)T

522. ~~CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): ELIGIBILITY DETERMINATION~~ CHILDREN'S DD HCBS STATE PLAN OPTION: ELIGIBILITY DETERMINATION. ~~The Department will make the final determination of a child's eligibility, based upon the assessments administered by the Department. Initial and annual assessments must be performed by the Department or its contractor. The purpose of the eligibility assessment is to determine a participant's eligibility for developmental disabilities services in accordance with Section 66-402, Idaho Code, and Sections 500 through 506 of these rules, to determine a participant's eligibility for children's home and community-based state plan option services in accordance with Section 662 of these rules, and to determine a participant's eligibility for ICF/ID level of care for children's waiver services in accordance with Section 682 of these rules~~ Prior to receiving Children's DD HCBS State Plan Option services as described in Section 523 of these rules, the participant must be determined to have a developmental disability in accordance with Section 66-402, Idaho Code, and Sections 500, 501, and 503 of these rules, and meet the criteria to receive Home and Community-Based Services. Final determination of an participant's eligibility will be made by the Department. (7-1-11)(7-1-19)T

01. ~~Initial Eligibility Assessment~~ Developmental Disability Determination. ~~For new applicants, an assessment must be completed by the Department or its contractor within thirty (30) calendar days from the date a complete application is submitted. The Department or its contractor will determine if a child meets established criteria for a developmental disability by completing the following:~~ (7-1-11)(7-1-19)T

a. Documentation of a participant's developmental disability diagnosis, demonstrated by: (7-1-19)T

i. A medical assessment that contains medical information that accurately reflects the current status of the participant or establishes categorical eligibility in accordance with Section 66-402(5)(a), Idaho Code; or (7-1-19)T

ii. The results of psychometric testing, if eligibility for developmental disabilities services is based on intellectual disability and there is no prior testing, or prior testing is inconclusive or invalid. Initial eligibility determinations also require documentation of diagnosis for a participant whose eligibility is based on developmental disabilities other than intellectual disability. (7-1-19)T

b. An assessment of functional skills that reflects the participant's current functioning. The Department, or its contractor, will administer a functional assessment for use in initial eligibility determination of developmental disability eligibility. Annually, a new functional assessment may be required if the assessor determines that additional documentation is necessary to determine the participant's level of care criteria and must be completed sixty (60) calendar days before the expiration of the current plan of service. (7-1-19)T

c. Medical, social, and developmental summary. (7-1-19)T

02. ~~Annual Eligibility Determination~~ Determination for Children's Home and Community Based State Plan Option. ~~Eligibility determination must be completed annually for current participants. The assessor must reassess the participant, or establish and document that the existing assessments reflect the participant's current level of care needs. At least sixty (60) calendar days before the expiration of the current plan of service~~ The Department or its contractor will determine if a child meets the established criteria necessary to receive children's home and community-based state plan option services by verifying: ~~(7-1-11)(7-1-19)T~~

a. ~~The eligibility determination process must be completed to determine level of care needs~~ The participant is birth through seventeen (17) years of age; and ~~(7-1-11)(7-1-19)T~~

b. ~~The assessor must provide the results of the eligibility determination to the participant.~~ The participant has a developmental disability as defined under Sections 500, 501, and 503 these rules and Section 66-402, Idaho Code, and have a demonstrated need for Children's HCBS state plan option services; and ~~(7-1-11)(7-1-19)T~~

c. The participant qualifies for Medicaid under an eligibility group who meets the needs-based criteria of the 1915(i) benefit for children with developmental disabilities and falls within the income requirements as specified in Attachment 2.2-A of the Idaho State Plan under Title XIX. ~~(7-1-19)T~~

03. ~~Determination of Developmental Disability Eligibility~~ Individualized Budget Methodology. The following four (4) categories are used when determining individualized budgets for children with developmental disabilities: ~~(7-1-11)(7-1-19)T~~

a. ~~The assessments that are required and completed by the Department or its contractor for determining a participant's eligibility for developmental disabilities services must include:~~ Children's DD - Level I. Children meeting developmental disabilities criteria. ~~(7-1-11)(7-1-19)T~~

i. ~~Medical, Social, and Developmental Assessment Summary;~~ ~~(7-1-11)~~

ii. ~~A functional assessment that reflects the participant's current functioning. The Department or its contractor will administer a functional assessment for use in initial eligibility determination of developmental disability eligibility. Thereafter, a new functional assessment will be required if the assessor determines that additional documentation is necessary to determine the participant's level of care criteria.~~ ~~(7-1-11)~~

b. ~~The Department or its contractor must obtain the following:~~ Children's DD - Level II. ~~(7-1-11)(7-1-19)T~~

i. ~~A medical assessment that contains medical information that accurately reflects the current status of the participant or establishes categorical eligibility in accordance with Section 66-402(5)(a), Idaho Code;~~ Children who qualify based on functional limitations when their composite full-scale standard score of less than fifty (50); or ~~(7-1-11)(7-1-19)T~~

ii. ~~The results of psychometric testing if eligibility for developmental disabilities services is based on intellectual disability and there is no prior testing, or prior testing is inconclusive or invalid. Initial eligibility determinations also require documentation of diagnosis for participants whose eligibility is based on developmental disabilities other than intellectual disability~~ Children who have an overall standard score up to fifty-three (53) when combined with a maladaptive behavior score of greater than one (1) to less than two (2) standard deviations from the mean. ~~(7-1-11)(7-1-19)T~~

c. Children's DD - Level III. ~~(7-1-19)T~~

i. Children who qualify based on functional limitations when their composite full-scale standard score is less than fifty (50); and ~~(7-1-19)T~~

ii. Have an autism spectrum disorder diagnosis. ~~(7-1-19)T~~

d. Children's DD - Level IV. Children who qualify based on maladaptive behaviors when their maladaptive behavior score is two (2) standard deviations or greater from the mean. (7-1-19)T

04. ~~ICF/ID Level of Care Determination for Waiver Services~~ **Participant Notification of Budget Amount.** ~~The Department or its contractor will determine ICF/ID level of care for children in accordance with Section 584 of these rules~~ **The Department, or its contractor, notifies each participant of his set budget amount as part of the eligibility determination process. The notification will include how the participant may appeal the set budget amount. (7-1-11)(7-1-19)T**

05. ~~Determination for Children's Home and Community Based State Plan Option~~ **Annual Re-Evaluation.** ~~The Department or its contractor will determine if a child meets the established criteria necessary to receive children's home and community-based state plan option services in accordance with Section 662 of these rules~~ **Individualized budgets will be re-evaluated annually. At the request of the participant, the Department, or its contractor, will also re-evaluate the set budget amount when there are documented changes that may support placement in a different budget category as outlined in Subsection 522.03 of this rule. (7-1-11)(7-1-19)T**

523. ~~(RESERVED)~~ CHILDREN'S DD HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.

All children's Home and Community-Based Services must be identified on a plan of service developed by the family-centered planning team. The following services must be prior authorized and are reimbursable when provided in accordance with these rules. (7-1-19)T

01. **Respite.** Respite provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver or in response to a family emergency or crisis. Respite may be provided by a qualified agency provider DDA or by an independent respite provider. An independent respite provider may be a relative of the participant. Payment for respite does not include room and board. Respite may be provided in the participant's home, the private home of the independent respite provider, a DDA, or in the community. The following limitations apply: (7-1-19)T

a. Respite must not be provided on a continuous, long-term basis as a daily service that would enable an unpaid caregiver to work. (7-1-19)T

b. Respite must only be offered to participants living with an unpaid caregiver who requires relief. (7-1-19)T

c. Respite cannot exceed fourteen (14) consecutive days. (7-1-19)T

d. Respite must not be provided at the same time other medicaid services are being provided with the exception of when an unpaid caregiver is receiving family education. (7-1-19)T

e. The respite provider must not use restraints on participants, other than physical restraints in the case of an emergency. Physical restraints may be used in an emergency to prevent injury to the participant or others and must be documented in the participant's record. (7-1-19)T

f. When respite is provided as group respite, the following applies: (7-1-19)T

i. When group respite is center-based, there must be a minimum of one (1) qualified staff providing direct services to every two (2) to six (6) participants. As the number and severity of the participants with functional impairments or behavioral needs increase, the staff-to-participant ratio must be adjusted accordingly. (7-1-19)T

ii. When group respite is community-based, there must be a minimum of one (1) qualified staff providing direct services to two (2) or three (3) participants. As the number and severity of the participants with functional impairments or behavioral needs increase, the staff-to-participant ratio must be adjusted accordingly. (7-1-19)T

g. Respite cannot be provided as center-based by an independent respite provider. An independent respite provider may only provide group respite when the following are met: (7-1-19)T

- i. The independent respite provider is a relative; and (7-1-19)T
- ii. Is delivering respite to no more than three (3) eligible siblings; and (7-1-19)T
- iii. The service is delivered in the home of the participants or the independent respite provider. (7-1-19)T

02. Community-Based Supports. Community-based supports provides assistance to an participant with a disability by facilitating the participant's independence and integration into the community. This service provides an opportunity for participants to explore their interests, practice skills learned in other therapeutic environments, and learn through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization, personal care, relationship building, and participation in leisure and community activities. Community-based supports must: (7-1-19)T

- a. Not supplant services provided in school or therapy, or supplant the role of the primary caregiver; (7-1-19)T
- b. Ensure the participant is involved in age-appropriate activities in environments typical peers access according to the ability of the participant; and (7-1-19)T
- c. Have a minimum of one (1) qualified staff providing direct services to two (2) or three (3) participants when provided as group community-based supports. As the number and severity of the participants with functional impairments or behavioral needs increase, the staff participant ratio must be adjusted accordingly. (7-1-19)T

03. Family Education. Family education is professional assistance to family members, or others, who participate in caring for the eligible participant to help them better meet the needs of the participant. It offers education that is specific to the needs of the family and participant as identified on the plan of service. Family education is delivered to families, or others, who participate in caring for the eligible participant to provide an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to the participant's diagnoses. (7-1-19)T

- a. Family education providers must maintain documentation of the training in the participant's record including the provision of activities outlined in the plan of service. (7-1-19)T
- b. Family education may be provided in a group setting not to exceed five (5) participants' families. (7-1-19)T

04. Family-Directed Community Supports (FDCS). Families of participants eligible for the children's home and community-based state plan option may choose to direct their individualized budget rather than receive the traditional services described in Subsections 523.01 through 523.04 of this rule when the participant lives at home with his parent or legal guardian. All services provided under FDCS option must be delivered on a one-to-one basis, must be identified on a plan of service developed by the family-centered planning team, and must be prior authorized. The requirements for this option are outlined in Subsections 520 through 522, 524.01-03, 523.06, 524.07-10, 525.01, and 528, of these rules, and IDAPA 16.03.13, "Consumer-Directed Services." (7-1-19)T

05. Limitations. (7-1-19)T

- a. HCBS state plan option services are limited by the participant's individualized budget amount. (7-1-19)T
- b. Services offered in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," may not be authorized under these rules. (7-1-19)T
- c. Duplication of services cannot be provided. Services are considered duplicate when: (7-1-19)T

- i. An adaptive equipment and support service address the same goal; (7-1-19)T
 - ii. Multiple adaptive equipment items address the same goal; (7-1-19)T
 - iii. Goals are not separate and unique to each service provided; or (7-1-19)T
 - iv. When more than one (1) service is provided at the same time, unless otherwise authorized. (7-1-19)T
- d.** For the children's HCBS state plan option services listed in Subsections 523.01, 523.02, and 523.03 of this rule, the following are excluded for Medicaid payment: (7-1-19)T
- i. Vocational services; (7-1-19)T
 - ii. Educational services; and (7-1-19)T
 - iii. Recreational services. (7-1-19)T

06. HCBS Compliance. Providers of children's developmental disability services are responsible for ensuring that they meet the setting quality requirements described in Section 313 of these rules, as applicable, and must comply with associated Department quality assurance activities. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. (7-1-19)T

524. ~~CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): COVERAGE AND LIMITATIONS~~ CHILDREN'S DD HCBS STATE PLAN OPTION: PLAN OF SERVICE PROCESS.

The scope of these rules defines prior authorization for the following Medicaid developmental disabilities services for children included in Section 310 of these rules: In collaboration with the participant, the Department must ensure that the participant has one (1) plan of service. This plan of service is developed within the individualized participant budget referred to in Section 522 of these rules and must identify all services. The plan of service must identify services and supports if available outside of Medicaid-funded services that can help the participant meet desired goals. Paid plan development must be provided by the Department, or its contractor, in accordance with Section 316 of these rules. (7-1-16)(7-1-19)T

01. ~~Children's Home and Community-Based State Plan Option Services~~ History and Physical. Children's home and community based state plan option services as described in Sections 660 through 666 of these rules; and Prior to the development of the plan of service, the plan developer must obtain a current history and physical completed by a practitioner of the healing arts. This is required at least annually or more frequently as determined by the practitioner. For participants in Healthy Connections, the Healthy Connections physician may conduct the history and physical and refer the participant for other evaluations. (7-1-11)(7-1-19)T

02. ~~Children's DD Waiver Services~~ Plan of Service Development. Children's DD waiver services as described in Sections 680 through 686 of these rules The plan of service must be developed with the child participant, the participant's decision-making authority, and facilitated by the Department, or its designee. If the participant is unable to attend the family-centered planning (FCP) meeting, the plan of service must contain documentation to justify the participant's absence. With the decision-making authority's consent, the family-centered planning team may include other family members or participants who are significant to the participant. (7-1-11)(7-1-19)T

03. Requirements for Collaboration. Providers of Home and Community-Based Services must coordinate with the family-centered planning team as specified on the plan of service. (7-1-19)T

04. Plan Monitoring. The family-centered planning team must identify the frequency of monitoring, which must be at least every six (6) months and document the plan monitor's name along with the monitoring frequency on the plan. The plan developer is considered the plan monitor and must meet face-to-face with the participant and the participant's decision-making authority at least annually. Plan monitoring includes reviewing the plan of service with the participant and the participant's decision-making authority to identify the current status of

programs, identifying any barriers to services, and making changes to the plan of service if needed. (7-1-19)T

05. Provider Status Reviews. The service providers identified in Subsection 523.03 of these rules must report the participant's progress toward goals to the plan monitor. The provider must complete a six (6) month and annual provider status review. The six (6) month status review must be submitted thirty (30) days prior to the six (6) month date listed on the plan of service and provider status review must be submitted to the plan monitor forty-five (45) calendar days prior to the expiration of the existing plan of service. (7-1-19)

06. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan and these adjustments must be based on changes in a participant's need and requested by the parent or legal guardian. Adjustment of the plan of service requires the decision-making authority's signature and prior authorization by the Department. The Department will distribute the addendum to the providers involved in the addendum's implementation. Upon receipt by the provider, the addendum must be reviewed, signed, and returned to the Department, with a copy maintained in the participant's record. (7-1-19)T

07. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (7-1-19)T

08. Annual Eligibility Determination Results. An annual determination must be completed in accordance with Section 522 of these rules. (7-1-19)T

09. Adjustments to the Annual Budget and Services. The annual budget may be adjusted when there are documented changes that may support placement in a different budget category as identified in Section 522 of these rules. Services may be adjusted at any time during the plan year. (7-1-19)T

10. Reapplication After a Lapse in Service. For participants who are re-applying for service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (7-1-19)T

525. ~~CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): PROCEDURAL REQUIREMENTS~~ CHILDREN'S DD HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS.
Prior to the development of the plan of service, the plan developer will gather and make referrals for the following information to facilitate the family-centered planning process: (7-1-16)(7-1-19)T

01. ~~Eligibility Determination Documentation~~ Requirements for Prior Authorization. *Eligibility determination documentation completed by the Department or its contractor as defined in Subsection 522.03 of these rules* Prior authorization is to ensure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization is intended to help ensure the provision of necessary and appropriate services and supports. Services are reimbursable if they are identified on the authorized plan of service and are consistent with rules for HCBS as described in Sections 310 through 313 and 316 and 317 of these rules, and for the specific services included on the plan. Delivery of each service identified on the plan of service cannot be initiated until the plan has been signed by the parent or participant's decision-making authority, the provider agency responsible for service provision, and has been authorized by the Department. (7-1-11)(7-1-19)T

02. ~~History and Physical~~ Requirements for Supervision. *A current history and physical completed by a practitioner of the healing arts is required at least annually or more frequently as determined by the practitioner. For participants in Healthy Connections, the Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations.* All DDA support services must be provided under supervision. The supervisor must meet the qualifications as outlined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 575, "Children's Habilitation Intervention Services". The observation and review of the direct services performed by all staff on at least a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the services as defined in this rule set. (7-1-11)(7-1-19)T

03. ~~Discipline Specific Assessments~~ Requirements for Quality Assurance. *Participants must be referred for an occupational therapy, physical therapy, or speech language pathology assessment when the*

~~participant has a targeted need in one of these disciplines. The assessment is used to guide the provision of services identified on the plan of service. Providers of children's home and community-based state plan option services must demonstrate high quality of services through an internal quality assurance review process.~~ (7-1-11)(7-1-19)T

04. ~~Additional—Information~~ General Requirements for Program Documentation. ~~Gather assessments and information related to the participant's medical conditions, risk of deterioration, living conditions, individual goals, and behavioral or psychiatric needs. The provider must maintain records for each participant served. Each participant's record must include documentation of the participant's involvement in and response to the services provided. Program documentation must be maintained by the independent provider or DDA in accordance with IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, and Misconduct," Section 101. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. For each participant, the following program documentation is required:~~ (7-1-11)(7-1-19)T

- ~~a. Date and time of visit; (7-1-19)T~~
- ~~b. Support services provided during the visit; (7-1-19)T~~
- ~~c. A statement of the participant's response to the service; (7-1-19)T~~
- ~~d. Length of visit, including time in and time out; (7-1-19)T~~
- ~~e. Location of service; and (7-1-19)T~~
- ~~f. Signature of the individual providing the service and date signed. (7-1-19)T~~

05. Community-Based Supports Documentation. ~~In addition to the general requirements listed in Subsection 525.04 of this rule, the supervisor must complete at a minimum, six (6) month and annual provider status reviews for community-based support services provided. These provider status reviews must be completed more frequently when required on the plan of service and must:~~ (7-1-19)T

- ~~a. Be submitted to the plan monitor; and (7-1-19)T~~
- ~~b. Be submitted on Department-approved forms. (7-1-19)T~~

06. Family Education Documentation. ~~In addition to the general requirements listed in Subsection 525.04 of this rule, the DDA must survey the parent or legal guardian's satisfaction of the service immediately following a family education session.~~ (7-1-19)T

526. ~~CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): PLAN OF SERVICE PROCESS~~ CHILDREN'S DD HCBS STATE PLAN OPTION: PROVIDER QUALIFICATIONS AND DUTIES.

~~In collaboration with the participant, the Department must ensure that the participant has one (1) plan of service. This plan of service is developed within the individualized participant budget referred to in Section 527 of these rules and must identify all services and supports. The participant and his parent or legal guardian may develop their own plan or use a paid or non paid plan developer to assist with plan development. The plan of service must identify services and supports if available outside of Medicaid-funded services that can help the participant meet desired goals All providers of HCBS state plan option services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department.~~ (7-1-11)(7-1-19)T

01. Plan-Development Respite. ~~Paid plan development must be provided by the Department or its contractor in accordance with Section 316 of these rules. Non paid plan development may be provided by the family, or a person of their choosing, in accordance with the Home and Community-Based Services (HCBS) regulations in Section 316 of these rules, when this person is not a paid provider of services identified on the child's plan of service. Respite may be provided by an agency that is certified as a DDA or by an independent respite provider. An independent respite provider is an individual who has entered into a provider agreement with the Department.~~

Providers of respite must meet the following minimum qualifications: (7-1-16)(7-1-19)T

~~a. The plan developer is responsible for the documentation of the developed plan and any subsequent plan changes as determined by the family-centered planning team. Must be at least sixteen (16) years of age when employed by a DDA; or~~ (7-1-16)(7-1-19)T

~~b. Individuals responsible for facilitating the person-centered planning meeting and developing the plan of service cannot be providers of direct services to the participant. Must be at least eighteen (18) years of age and be a high school graduate, or have a GED, to act as an Independent Respite Provider; and~~ (7-1-16)(7-1-19)T

~~c. Meet the qualifications prescribed for the type of services to be rendered, or must be an individual selected by the participant, the family, or the participant's guardian;~~ (7-1-19)T

~~d. Have received instructions in the needs of the participant who will be provided the service;~~ (7-1-19)T

~~e. Demonstrate the ability to provide services according to a plan of service;~~ (7-1-19)T

~~f. Must satisfactorily complete a criminal history background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks,"; and~~ (7-1-19)T

~~g. When employed by a DDA, must be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." Independent respite providers must be certified in CPR and first aid prior to delivering services and must maintain current certification thereafter.~~ (7-1-19)T

~~02. **Plan of Service Development Community-Based Support.** The plan of service must meet the requirements described in Section 317 of these rules. The service plan must be developed with the child participant, the participant's decision making authority, and facilitated by the Department or its designee. If the participant is unable to attend the family-centered planning (FCP) meeting, the Plan of Service must contain documentation to justify the participant's absence. With the decision-making authority's consent, the family-centered planning team may include other family members or individuals who are significant to the participant. Community-based supports must be provided by an agency certified as a DDA with staff who are capable of supervising the direct services provided. Providers of community-based supports must meet the following minimum qualifications:~~

(7-1-16)(7-1-19)T

~~a. In developing the plan of service, the family-centered planning team must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. The development of the service plan must be conducted in accordance with the Home and Community Based Services requirements in Section 317 of these rules. Must be at least eighteen (18) years of age;~~ (7-1-16)(7-1-19)T

~~b. The plan of service must identify, at a minimum, the type of service to be delivered, goals and desired outcomes to be addressed within the plan year, strengths and preferences of the participant, including the participant's safety and the safety of those around the participant, target dates, and methods for collaboration. Must be a high school graduate or have a GED;~~ (7-1-16)(7-1-19)T

~~c. Have received instructions in the needs of the participant who will be provided the service;~~ (7-1-19)T

~~d. Demonstrate the ability to provide services according to a plan of service;~~ (7-1-19)T

~~e. Must have six (6) months supervised experience working with children with developmental disabilities. This can be achieved in the following ways:~~ (7-1-19)T

~~i. Have previous work experience gained through paid employment, university practicum experience, or internship; or~~ (7-1-19)T

ii. Have on-the-job supervised experience gained through employment at a DDA with increased supervision. Experience is gained by completing at least six (6) hours of job shadowing prior to the delivery of direct support services, and a minimum of weekly face-to-face supervision with the supervisor for a period of six (6) months while delivering services. (7-1-19)T

iii. For individuals providing community-based supports to children birth to age three (3), the six (6) months of documented experience must be with infants, toddlers, or children birth to age three (3) years of age with developmental delays or disabilities. (7-1-19)T

f. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide community-based supports. (7-1-19)T

03. ~~No Duplication of Services~~ Family Education. ~~The plan developer must ensure that there is no duplication of services.~~ Family Education can be provided by an agency certified as a DDA or an individual who holds an independent habilitation intervention provider agreement with the Department in one (1) of the following: Providers of Family Education must meet one (1) of the following minimum qualifications: (7-1-11)(7-1-19)T

a. Must meet the qualifications of an intervention specialist as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 575.03; or (7-1-19)T

b. Meet the minimum qualifications of an intervention professional as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 575.04; or (7-1-19)T

c. Meet the minimum qualifications to provide services under a Department-approved Evidence-Based Model (EBM) intervention specialist, as outlined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 575.06; or (7-1-19)T

d. Meet the minimum qualification to provide services under a Department-approved Evidence-Based Model (EBM) intervention professional, as outlined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 575.07. (7-1-19)T

~~**04. Plan Monitoring. The family-centered planning team must identify the frequency of monitoring, which must be at least every six (6) months, and document the plan monitor's name along with the monitoring frequency on the plan. The plan developer is considered the plan monitor and must meet face to face with the participant and the participant's decision-making authority at least annually. Plan monitoring must include the following:**~~ (7-1-16)

~~**a. Review of the plan of service with the participant and the participant's decision-making authority to identify the current status of programs and changes if needed;**~~ (7-1-16)

~~**b. Maintain contact with service providers to identify and remediate barriers to service provision;**~~ (7-1-16)

~~**c. Discuss with the participant and his decision-making authority their satisfaction regarding quality and quantity of services; and**~~ (7-1-16)

~~**d. Review of provider status reviews for compliance with the plan of service.**~~ (7-1-16)

~~**05. Provider Status Reviews. The service providers in Sections 664 and 684 of these rules must report to the plan monitor the participant's progress toward goals. The provider must complete a six (6) month and annual provider status review. The provider status review must be submitted to the plan monitor within forty five (45) calendar days prior to the expiration of the existing plan of service.**~~ (7-1-11)

~~**06. Informed Consent. The participant and the participant's decision-making authority must make decisions regarding the type and amount of services required.**~~ (7-1-16)

~~a. Prior to plan development, the plan developer must document that they have provided information and support to the participant and the participant's decision making authority to maximize their ability to make informed choices regarding the services and supports they receive and from whom. (7-1-16)~~

~~b. During plan development and amendments, planning team members must document whether they believe the plan is in accordance with the participant's choices of the services and supports identified in the meeting and whether they believe the plan meets the needs of the participant. (7-1-16)~~

~~c. If there is a conflict that cannot be resolved among the family-centered planning members or if the participant or the participant's decision making authority does not believe the plan meets the participant's needs or represents the participant's choice, the plan or amendment may be referred to the Bureau of Developmental Disability Services to negotiate a resolution with the planning team. (7-1-16)~~

~~07. **Program Implementation Plan.** Providers of children's waiver services listed under Section 684 of these rules must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service. (7-1-13)~~

~~a. The implementation plan must be completed within fourteen (14) calendar days after the initial provision of service, and revised whenever participant needs change. (7-1-11)~~

~~b. Documentation of implementation plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, and the signature of the person making the change complete with his title and the date signed. (7-1-11)~~

~~08. **Addendum to the Plan of Service.** A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes that result in the need for an addition or reduction of a service, or a change in a provider. Additional assessments or information may be clinically necessary. Adjustment of the plan of service requires the decision-making authority's signature and prior authorization by the Department. The Department will distribute the addendum to the providers involved in the addendum's implementation. Upon receipt by the provider, the addendum must be reviewed, signed, and returned to the Department, with a copy maintained in the participant's record. (7-1-16)~~

~~09. **Annual Reauthorization of Services.** A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (7-1-11)~~

~~a. **Annual Eligibility Determination Results.** An annual determination must be completed in accordance with Section 522 of these rules. (7-1-11)~~

~~b. **Plan Developer Responsibilities for Annual Reauthorization.** A new plan of service must be provided to the Department by the plan developer at least ten (10) calendar days prior to the expiration date of the current plan. Prior to this, the plan developer must: (7-1-13)~~

~~i. Notify the providers who appear on the plan of service of the annual review date. (7-1-11)~~

~~ii. Obtain a copy of the current annual provider status review from each provider for use by the family-centered planning team. Each provider status review must meet the requirements in Subsection 526.06 of these rules. (7-1-11)~~

~~iii. Convene the family-centered planning team to develop a new plan of service. (7-1-11)~~

~~c. **Evaluation and Prior Authorization of the Plan of Service.** The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 520 and 526 of these rules. (7-1-11)~~

~~d. **Adjustments to the Annual Budget and Services.** The annual budget may be adjusted when there are~~

documented changes that may support placement in a different budget category as identified in Section 527 of these rules. Services may be adjusted at any time during the plan year. (7-1-13)

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after at least a thirty (30) calendar day lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (7-1-11)

527. ~~CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA); PROVIDER REIMBURSEMENT~~ CHILDREN'S DD HCBS STATE PLAN OPTION: PROVIDER REIMBURSEMENT.

Providers are reimbursed on a fee-for-service basis for services identified on the participant's plan of service and within the participant's individualized budget. The Department will monitor the budget setting methodology on an ongoing basis to ensure that participant needs are accurately reflected in the methodology. Providers are reimbursed on a fee-for-service basis for services identified on the participant's plan of service and within the participant's individualized budget. The Department will monitor the budget setting methodology on an ongoing basis to ensure that participant needs are accurately reflected in the methodology. (7-1-11)(7-1-19)T

01. Individualized Budget Methodology Reimbursement. *The following five (5) categories are used when determining individualized budgets for children with developmental disabilities: The statewide reimbursement rate for children's HCBS state plan option services listed in Subsections 523.01 through 523.04 of these rules was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service, adjusted for employment-related expenditures, program-related costs, and general and administrative costs based on a cost survey as described in Subsection 527.02 of this rule. Reimbursement rates are set at a percentage of the statewide target reimbursement rate. The Department will take into consideration the factors of efficiency, economy, quality of care, and access to care when determining rates.* (7-1-11)(7-1-19)T

- a. HCBS State Plan Option. Children meeting developmental disabilities criteria.* (7-1-11)
- b. Children's DD Waiver—Level I.* (7-1-11)
- i. Children meeting ICF/ID level of care criteria who qualify based on functional limitations when their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or* (7-1-11)
- ii. Children who have an overall age equivalency up to fifty-three percent (53%) of their chronological age when combined with a General Maladaptive Index between minus seventeen (-17), and minus twenty-one (-21) inclusive.* (7-1-11)
- e. Children's DD Waiver—Level II.* (7-1-11)
- i. Children meeting ICF/ID level of care criteria who qualify based on functional limitations when their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; and* (7-1-11)
- ii. Have an autism spectrum disorder diagnosis.* (7-1-11)
- d. Children's DD Waiver—Level III. Children meeting ICF/ID level of care criteria who qualify based on maladaptive behaviors when their General Maladaptive Index is minus twenty-two (-22) or less.* (7-1-11)
- e. Act Early Waiver.* (7-1-11)
- i. Children age three (3) through six (6) meeting ICF/ID level of care criteria who qualify based on maladaptive behaviors when their General Maladaptive Index is minus twenty-two (-22) or less, and their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or* (7-1-11)
- ii. Children age three (3) through six (6) meeting ICF/ID level of care criteria who have an autism spectrum disorder diagnosis.* (7-1-11)

~~02. **Participant Notification of Budget Amount Cost Survey.** The Department notifies each participant of his set budget amount as part of the eligibility determination process. The notification will include how the participant may appeal the set budget amount. The Department will conduct a cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain cost data for employment-related expenditures, program-related costs, and general and administrative costs. (7-1-11)(7-1-19)T~~

~~03. **Annual Re-Evaluation Claim Forms.** Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes that may support placement in a different budget category as identified in this rule. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (7-1-13)(7-1-19)T~~

~~04. **Rates.** The reimbursement rates calculated for children's HCBS include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation. (7-1-19)T~~

~~528. **CHILDREN'S DEVELOPMENTAL DISABILITIES PRIOR AUTHORIZATION (PA); DEPARTMENT'S QUALITY ASSURANCE AND IMPROVEMENT PROCESSES CHILDREN'S DD HCBS STATE PLAN OPTION; DEPARTMENT'S QUALITY ASSURANCE AND IMPROVEMENT PROCESSES.** Quality assurance activities will include the observation of service delivery with participants, review of participant records, and complete satisfaction interviews. All providers of support services must grant the Department immediate access to all information required to review compliance with these rules. (7-1-19)T~~

~~01. **Quality Assurance.** Quality Assurance consists of audits and reviews to ensure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) calendar days after the results are received. The Department may terminate authorization of service or the provider agreement for providers who do not comply with the corrective action plan. If the Department finds a provider's deficiency or deficiencies immediately jeopardize the health or safety of its participants, the Department may immediately terminate the provider agreement. The Department will conduct quality assurance by collaborating with providers to complete audits and reviews to ensure compliance with the Department's rules and regulations. These findings may lead to quality improvement activities to enhance provider processes and outcomes for the child. If problems are identified that impact health and safety or are not resolved through quality improvement activities, implementation of a corrective action process may occur. (7-1-11)(7-1-19)T~~

~~02. **Quality Improvement.** The Department may gather and utilize information from participants and providers to evaluate customer satisfaction, participant satisfaction, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings lead to quality improvement activities to improve provider processes and outcomes for participants. Quality improvement consists of the Department working with the provider to resolve identified issues and enhance services provided. Quality improvement activities must include: (7-1-11)(7-1-19)T~~

~~a. **Consultation;** (7-1-19)T~~

~~b. **Technical assistance and recommendations; or** (7-1-19)T~~

~~c. **Corrective Action.** (7-1-19)T~~

~~03. **Plan of Service Review Corrective Action.** The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, services continue to be clinically necessary, services continue to be the choice of the participant, and services constitute appropriate care to warrant continued authorization or need for the service. Corrective action is a formal process used by the Department to address significant, ongoing, or unresolved deficient practice identified during the review process as provided in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, and includes but is not limited to: (7-1-11)(7-1-19)T~~

~~a. **Issuance of a corrective action plan;** (7-1-19)T~~

b. Referral to Medicaid Program Integrity Unit; or (7-1-19)T

c. Action against a provider agreement. (7-1-19)T

~~**04.** **HCBS Compliance.** Providers of children's developmental disability services are responsible for ensuring that they meet the setting quality requirements described in Section 313 of these rules, as applicable, and must comply with associated Department quality assurance activities. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. (7-1-16)~~

(BREAK IN CONTINUITY OF SECTIONS)

~~**CHILDREN'S HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION**
(Sections 660-669)~~

~~**660. CHILDREN'S HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION.** In accordance with Section 1915i of the Social Security Act, the Department will pay for home and community based services provided by individuals or agencies that have entered into a provider agreement with the Department. Services provided by a developmental disabilities agency to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements. (7-1-18)~~

~~**661. Children's HCBS State Plan Option: Definitions.** For the purposes of these rules, the definitions in Section 521 of these rules apply. Additionally, the following terms apply to the Children's Home and Community Based Services State Plan Option: (7-1-11)~~

~~**01. Agency.** A developmental disabilities agency (DDA) as defined in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)~~

~~**02. Annual.** Every three hundred sixty five (365) days except during a leap year which equals three hundred sixty six (366) days. (7-1-11)~~

~~**03. Clinical Supervisor.** For the purposes of these rules, the clinical supervisor is the professional responsible for the supervision of DDA staff as outlined in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-18)~~

~~**04. Community.** Natural, integrated environments outside of the home, school, or DDA center based settings. (7-1-11)~~

~~**05. Developmental Disabilities Agency (DDA).** A DDA is an agency that is: (7-1-11)~~

~~**a.** A type of developmental disabilities facility, as defined in Section 39-4604(7), Idaho Code, that is non-residential and provides services on an outpatient basis; (7-1-11)~~

~~**b.** Certified by the Department to provide home and community based services to people with developmental disabilities, in accordance with these rules; (7-1-11)~~

~~**c.** A business entity, open for business to the general public; and (7-1-11)~~

~~**d.** Primarily organized and operated to provide home and community based services and the~~

~~corresponding assessments to people with developmental disabilities. DDA services include evaluations, diagnostic, treatment, and support services that are provided on an outpatient basis to persons with developmental disabilities and may be community-based, home-based, or center-based in accordance with the requirements of this chapter. (7-1-11)~~

~~**06. Home and Community Based Services State (HCBS) Plan Option.** The federal authority under section 1915(i) of the Social Security Act that allows a state to provide through a state plan amendment, medical assistance for home and community based services for elderly and individuals with disabilities, without determining that without the provision of services the individuals would require institutional level of care. (7-1-11)~~

~~**07. Human Services Field.** A particular area of academic study in health care, social services, education, behavioral science or counseling. (7-1-11)~~

~~**08. Integration.** The process of promoting a life for individuals with developmental disabilities that is as much as possible like that of other citizens of the community, including living in the community and having access to community resources. A further goal of this process is to enhance the social image and personal competence of individuals with developmental disabilities. (7-1-11)~~

~~**09. Paraprofessional.** A person qualified to provide direct support services which include respite and habilitative supports. (7-1-11)~~

~~**10. Professional.** A person qualified to provide direct intervention services which include habilitative intervention, therapeutic consultation, family education, family training, interdisciplinary training, and crisis intervention. (7-1-11)~~

~~**11. Support Services.** Support services may provide supervision for a participant, as well as may provide assistance to a participant by facilitating integration into the community. (7-1-11)~~

~~**662. Children's HCBS State Plan Option: Participant Eligibility.** Children's Home and Community Based State Plan Option eligibility will be determined by the Department as described in Section 520 of these rules. HCBS state plan option participants must meet the following requirements: (7-1-11)~~

~~**01. Age of Participants.** Participants eligible to receive children's HCBS must be birth through seventeen (17) years of age. (7-1-11)~~

~~**02. Eligibility Determinations.** The Department must determine that prior to receiving children's HCBS state plan option services, an individual must be determined to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, and have a demonstrated need for Children's HCBS state plan option services. (7-1-11)~~

~~**03. Financial Eligibility.** The Department must determine that prior to receiving children's HCBS state plan option services, the individual is in an eligibility group covered under the Title XIX Medicaid State plan, and has an income that does not exceed one hundred fifty percent (150%) of the Federal Poverty Level (FPL). (7-1-13)~~

~~**663. Children's HCBS State Plan Option: Coverage And Limitations.** All children's home and community based services must be identified on a plan of service developed by the family-centered planning team, and must be recommended by a physician or other practitioner of the healing arts. The following services are reimbursable when provided in accordance with these rules: (7-1-16)~~

~~**01. Respite.** Respite provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver. Respite is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Respite may be provided in the participant's home, the private home of the respite provider, a DDA, or in the community. Payment for respite services are not made for room and board. (7-1-11)~~

- ~~a. Respite must only be offered to participants living with an unpaid caregiver who requires relief. (7-1-11)~~
 - ~~b. Respite cannot exceed fourteen (14) consecutive days. (7-1-11)~~
 - ~~c. Respite must not be provided at the same time other Medicaid services are being provided. (7-1-11)~~
 - ~~d. Respite must not be provided on a continuous, long-term basis as a daily service that would enable an unpaid caregiver to work. (7-1-11)~~
 - ~~e. The respite provider must not use restraints on participants, other than physical restraints in the case of an emergency. Physical restraints may be used in an emergency to prevent injury to the participant or others, and must be documented in the participant's record. (7-1-11)~~
 - ~~f. When respite is provided as group respite, the following applies: (7-1-11)~~
 - ~~i. When group respite is center-based, there must be a minimum of one (1) qualified staff providing direct services to every six (6) participants. As the number and severity of the participants with functional impairments or behavioral issues increases, the staff to participant ratio must be adjusted accordingly. (7-1-11)~~
 - ~~ii. When group respite is community-based, there must be a minimum of one (1) qualified staff providing direct services to every three (3) participants. As the number and severity of the participants with functional impairments or behavioral issues increases, the staff to participant ratio must be adjusted accordingly. (7-1-11)~~
 - ~~g. Respite cannot be provided as group or center-based respite when delivered by an independent respite provider. (7-1-11)~~
 - ~~h. For Act Early waiver participants, the cost of respite services cannot exceed ten (10) percent of the child's individualized budget amount to ensure the child receives the recommended amount of intervention based on evidence-based research. (7-1-11)~~
- ~~**02. Habilitative Supports.** Habilitative Supports provides assistance to a participant with a disability by facilitating the participant's independence and integration into the community. This service provides an opportunity for participants to explore their interests, practice skills learned in other therapeutic environments, and learn through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility; sensory-motor; communication; socialization; personal care; relationship building; and participation in leisure and community activities. Habilitative Supports must: (7-1-11)~~
- ~~a. Not supplant services provided in school or therapy; or supplant the role of the primary caregiver; (7-1-11)~~
 - ~~b. Ensure the participant is involved in age-appropriate activities and is engaging with typical peers according to the ability of the participant; and (7-1-11)~~
 - ~~c. Have a minimum of one (1) qualified staff providing direct services to every three (3) participants when provided as group habilitative supports. As the number and severity of the participants with functional impairments increases, the staff participant ratio shall be adjusted accordingly. (7-1-11)~~
- ~~**03. Family Education.** Family education is professional assistance to families to help them better meet the needs of the participant. It offers education to the parent or legal guardian that is specific to the individual needs of the family and child as identified on the plan of service. Family education is delivered to families to provide an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to their child's diagnoses. (7-1-11)~~

~~a. Family education may also provide assistance to the parent or legal guardian in educating other unpaid caregivers regarding the needs of the participant. (7-1-11)~~

~~b. The family education providers must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. (7-1-11)~~

~~c. Family education may be provided in a group setting not to exceed five (5) participants' families. (7-1-11)~~

~~04. **Family Directed Community Supports.** Families of participants eligible for the children's home and community based state plan option may choose to direct their individualized budget rather than receive the traditional services described in Subsections 663.01 through 663.03 of this rule when the participant lives at home with his parent or legal guardian. The requirements for this option are outlined in IDAPA 16.03.13 "Consumer Directed Services." (7-1-11)~~

~~05. **Limitations.** (7-1-11)~~

~~a. HCBS state plan option services are limited by the participant's individualized budget amount. (7-1-11)~~

~~b. For the children's HCBS state plan option services listed in Subsections 663.01, 663.02, and 663.04 of this rule, the following are excluded for Medicaid payment: (7-1-11)~~

~~i. Vocational services; and (7-1-11)~~

~~ii. Educational services. (7-1-11)~~

~~664. **Children's HCBS State Plan Option: Procedural Requirements.**~~

~~01. **General Requirements for Program Documentation.** The provider must maintain records for each participant served. Each participant's record must include documentation of the participant's involvement in and response to the services provided. For each participant, the following program documentation is required: (7-1-11)~~

~~a. Direct service provider information that includes written documentation of the service provided during each visit made to the participant, and contains, at a minimum, the following information: (7-1-11)~~

~~i. Date and time of visit; and (7-1-11)~~

~~ii. Intervention and support services provided during the visit; and (7-1-11)~~

~~iii. A statement of the participant's response to the service; and (7-1-11)~~

~~iv. Length of visit, including time in and time out; and (7-1-11)~~

~~v. Specific place of service. (7-1-11)~~

~~vi. A copy of the above information will be maintained by the independent provider or DDA. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (7-1-11)~~

~~02. **Habilitative Supports Documentation.** In addition to the general requirements listed in Subsection 664.01 of this rule, the following must be completed: (7-1-11)~~

~~a. On a monthly basis, the habilitative support staff must complete a summary of the participant's response to the support service and submit the monthly summary to the clinical supervisor. (7-1-11)~~

~~b. The clinical supervisor reviews the summary on a monthly basis and when recommendations for changes to the type and amount of support are identified, submits the recommendations to the plan developer.~~

(7-1-11)

~~03. **Family Education Documentation.** In addition to the general requirements listed in Subsection 664.01 of this rule, the DDA must survey the parent or legal guardian's satisfaction of the service immediately following a family education session. (7-1-18)~~

~~04. **Reporting Requirements.** The clinical supervisor must complete at a minimum, six (6) month and annual provider status reviews for habilitative support services provided. These provider status reviews must be completed more frequently, when so required on the plan of service. (7-1-11)~~

~~a. Documentation of the six (6) month and annual reviews must be submitted to the plan monitor. (7-1-11)~~

~~b. The provider must use Department approved forms for provider status reviews. (7-1-11)~~

~~665. **Children's HCBS State Plan Option: Provider Qualifications And Duties.**~~

~~All providers of HCBS state plan option services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (7-1-11)~~

~~01. **Respite.** Respite services may be provided by an agency that is certified as a DDA and is capable of supervising the direct services provided, by an independent respite provider. An independent respite provider is an individual who has entered into a provider agreement with the Department. Providers of respite services must meet the following minimum qualifications: (7-1-18)~~

~~a. Must be at least sixteen (16) years of age when employed by a DDA; or (7-1-18)~~

~~b. Must be at least eighteen (18) years of age and be a high school graduate, or have a GED, to act as an independent respite provider; and (7-1-11)~~

~~c. Meet the qualifications prescribed for the type of services to be rendered, or must be an individual selected by the participant, the family, or the participant's guardian; and (7-1-11)~~

~~d. Have received instructions in the needs of the participant who will be provided the service; and (7-1-11)~~

~~e. Demonstrate the ability to provide services according to a plan of service; and (7-1-11)~~

~~f. Must satisfactorily complete a criminal history background check in accordance with IDAPA 16.05.06 "Criminal History and Background Checks"; and (7-1-11)~~

~~g. When employed by a DDA, must be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)." Independent respite providers must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter. (7-1-18)~~

~~02. **Habilitative Support Staff.** Habilitative supports must be provided by an agency certified as a DDA with staff who are capable of supervising the direct services provided. Providers of habilitative supports must meet the following minimum qualifications: (7-1-18)~~

~~a. Must be at least eighteen (18) years of age; (7-1-11)~~

~~b. Must be a high school graduate or have a GED; (7-1-11)~~

~~c. Have received instructions in the needs of the participant who will be provided the service; (7-1-11)~~

- ~~d. Demonstrate the ability to provide services according to a plan of service; (7-1-11)~~
- ~~e. Must have six (6) months supervised experience working with children with developmental disabilities. This can be achieved in the following ways: (7-1-11)~~
- ~~i. Have previous work experience gained through paid employment, university practicum experience, or internship; or (7-1-11)~~
- ~~ii. Have on-the-job supervised experience gained through employment at a DDA with increased supervision. Experience is gained by completing at least six (6) hours of job shadowing prior to the delivery of direct support services, and a minimum of weekly face-to-face supervision with the clinical supervisor for a period of six (6) months while delivering services. (7-1-18)~~
- ~~f. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative supports. (7-1-11)~~
- ~~g. In addition to the habilitative support qualifications listed in Subsections 665.02.a. through f. of this rule, habilitative support staff serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: (7-1-11)~~
- ~~i. Have transcribed courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education, or closely related coursework; or (7-1-11)~~
- ~~ii. Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist. (7-1-11)~~
- ~~**03. Family Education.** Family education must be provided by an agency certified as a DDA and with staff who are capable of supervising the direct services provided. Providers of family education must meet the following minimum qualifications: (7-1-18)~~
- ~~a. Must hold at least a bachelor's degree in a human services field from a nationally accredited university or college, and has: (7-1-11)~~
- ~~i. One (1) year experience providing care to children with developmental disabilities; (7-1-11)~~
- ~~ii. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide family education; or (7-1-11)~~
- ~~b. Individuals working as Developmental Specialists for children ages birth through three (3) or three (3) through seventeen (17), and individuals certified as Intensive Behavioral Interventionist professionals prior to July 1, 2011, are qualified to provide family education until June 30, 2013. The individual must meet the requirements of the Department approved competency coursework by June 30, 2013, to maintain his certification. (7-1-11)~~
- ~~e. Each professional providing family education services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. If the individual has not completed the required training during any yearly training period, he may not provide family education services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period. (7-1-11)~~
- ~~**04. Family Education for Children Birth to Three.** In addition to the family education qualifications listed in Subsections 665.03.a. through 665.03.e. of this rule, family education staff serving infants and toddlers from birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally supervised~~

~~experience with young children who have developmental disabilities and one (1) of the following: (7-1-11)~~

~~a. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or (7-1-11)~~

~~b. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or (7-1-11)~~

~~c. A bachelor's or master's degree in special education, elementary education, speech language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: (7-1-11)~~

~~i. Promotion of development and learning for children from birth to three (3) years; (7-1-11)~~

~~ii. Assessment and observation methods for developmentally appropriate assessment of young children; (7-1-11)~~

~~iii. Building family and community relationships to support early interventions; (7-1-11)~~

~~iv. Development of appropriate curriculum for young children, including IFSP and IEP development; (7-1-11)~~

~~v. Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and (7-1-11)~~

~~vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-11)~~

~~d. Electives closely related to the content under Subsection 665.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education. (7-1-11)~~

~~e. Developmental specialists who possess a bachelor's or master's degree listed above under Subsection 665.04.c.ii. of this rule, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement. (7-1-11)~~

~~f. When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: (7-1-11)~~

~~i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. (7-1-11)~~

~~ii. Satisfactory progress will be determined on an annual review by the Department. (7-1-11)~~

~~iii. Individuals who have an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as they demonstrate satisfactory progress on the plan and complete the requirements on the plan within three (3) years of their date of hire. (7-1-11)~~

~~**05. Requirements for Clinical Supervision.** All DDA services must be provided under the supervision of a clinical supervisor. The clinical supervisor must meet the qualifications to provide habilitative intervention as defined in Section 685 of these rules. Clinical supervisor(s) are professionals employed by a DDA on a continuous and regularly scheduled basis. (7-1-18)~~

~~a. The clinical supervisor is responsible for the oversight and supervision of service and support elements of the agency, including face to face supervision of agency staff providing direct services. (7-1-11)~~

~~b. The clinical supervisor must observe and review the direct services performed by all paraprofessional and professional staff on a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the services and support. (7-1-11)~~

~~c. Each DDA must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction. (7-1-18)~~

~~06. **Requirements for Collaboration.** Providers of home and community based services must coordinate with the family centered planning team as specified on the plan of service. (7-1-11)~~

~~07. **Requirements for Quality Assurance.** Providers of children's home and community based state plan option services must demonstrate high quality of services through an internal quality assurance review process. (7-1-11)~~

~~08. **DDA Services.** In order for a DDA to provide respite, habilitative supports, and family education the DDA must be certified to provide support services. Each DDA is required to provide habilitative supports. (7-1-11)~~

~~666. **Children's HCBS State Plan Option: Provider Reimbursement.**~~

~~01. **Reimbursement.** The statewide reimbursement rate for children's HCBS state plan option services listed in Subsections 663.01 through 663.03 of these rules was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service, adjusted for employment related expenditures, program related costs, and general and administrative costs based on a cost survey as described in Subsection 666.02 of this rule. Reimbursement rates are set at a percentage of the statewide target reimbursement rate. The Department will take into consideration the factors of efficiency, economy, quality of care, and access to care when determining rates. (7-1-11)~~

~~02. **Cost Survey.** The Department will conduct a cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain cost data for employment related expenditures, program related costs, and general and administrative costs. (7-1-11)~~

~~03. **Claim Forms.** Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (7-1-11)~~

~~04. **Rates.** The reimbursement rates calculated for children's HCBS include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation. (7-1-11)~~

667. -- 679. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

CHILDREN'S WAIVER SERVICES
(Sections 680—699)

~~680. **Children's Waiver Services.**~~

~~01. **Purpose of and Eligibility for Waiver Services.** Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible children to prevent unnecessary institutional placement, provide for the greatest degree autonomy and of independence possible, enhance the quality of life, encourage~~

~~individual choice, and achieve and maintain community integration. For a 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.~~ (7-1-16)

~~**02. Waiver Services Provided by a DDA.** Services provided by a developmental disabilities agency to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements.~~ (7-1-18)

~~**681. Children's Waiver Services: Definitions.**~~

~~For the purposes of Sections 680 through 686 of these rules, the following terms are used as defined below; in addition, the definitions in Sections 521 and 661 of these rules apply.~~ (7-1-11)

~~**01. Crisis.** An unanticipated event, circumstance, or life situation that places a participant at risk of at least one of the following:~~ (7-1-11)

~~**a.** Hospitalization;~~ (7-1-11)

~~**b.** Loss of housing;~~ (7-1-11)

~~**c.** Loss of employment;~~ (7-1-11)

~~**d.** Incarceration; or~~ (7-1-11)

~~**e.** Physical harm to self or others, including family altercation or psychiatric relapse.~~ (7-1-11)

~~**02. Intervention Services.** Intervention services include outcome-based therapeutic services, professional consultation services, and education and training for families caring for participants with developmental disabilities.~~ (7-1-11)

~~**03. Objective.** A behavioral outcome statement developed to address a particular need identified for a participant. An objective is written in measurable terms that specify a target date for completion, no longer than one (1) year in duration, and include criteria for successful attainment of the objective.~~ (7-1-11)

~~**04. Probe.** A probe is data gathered on an intermittent basis, after a baseline is established, to measure a participant's level of independent performance as related to an identified objective.~~ (7-1-11)

~~**05. Program Implementation Plan.** A plan that details how intervention goals from the plan of service will be accomplished.~~ (7-1-11)

~~**06. Specific Skill Assessment.** A type of assessment used to determine the baseline or the need for further supports or intervention for the discipline area being assessed.~~ (7-1-11)

~~**07. Telehealth.** Telehealth is an electronic real-time synchronized audio-visual contact between a consultant and participant related to the treatment of the participant. The consultant and participant interact as if they were having a face-to-face service.~~ (7-1-11)

~~**08. Treatment Fidelity.** Accurately and consistently administering a program or intervention from a manual, protocol, or model.~~ (7-1-11)

~~**682. Children's Waiver Services: Eligibility.**~~

~~Waiver eligibility will be determined by the Department as described in Section 522 of these rules. Children's waiver participants must meet the following requirements:~~ (7-1-11)

- 01. ~~Age of Participants.~~** ~~The following waiver programs are available for children:~~ (7-1-11)
- a.** ~~Children's DD Waiver. Children's DD waiver participants must be birth through seventeen (17) years of age.~~ (7-1-11)
- b.** ~~Act Early Waiver. Act Early waiver participants must be three (3) through six (6) years of age.~~ (7-1-11)
- 02. ~~Eligibility Determinations.~~** ~~The Department must determine that:~~ (7-1-11)
- a.** ~~The participant would qualify for ICF/ID level of care as set forth in Section 584 of these rules, if the waiver services listed in Section 683 of these rules were not made available; and~~ (7-1-11)
- b.** ~~The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must be made by a team of individuals with input from the family-centered planning team. Prior to any denial of services, it must be determined by the plan developer that services to correct the concerns of the team are not available.~~ (7-1-11)
- c.** ~~The average annual cost of waiver services and other medical services to participants would not exceed the average annual cost to Medicaid of ICF/ID care and other medical costs.~~ (7-1-11)
- d.** ~~Following the approval by the Department for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program.~~ (7-1-11)
- 03. ~~Additional Act Early Waiver Requirements.~~** ~~In addition to the requirements listed in Subsections 682.01 and 682.02 of this rule, a participant must have the following characteristics to qualify for Act Early waiver services:~~ (7-1-11)
- a.** ~~An autism spectrum diagnosis; or~~ (7-1-11)
- b.** ~~Self-injurious, aggressive, or severely maladaptive behavior as evidenced by a General Maladaptive Index score of minus twenty-two (-22) or below on a Department-approved assessment tool or other behavioral assessment indicators identified by the Department and a severe deficit, defined as having a composite full-scale functional age equivalency of fifty percent (50%) or less of the participant's chronological age.~~ (7-1-18)
- 04. ~~Children's Waiver Eligible Participants.~~** ~~A participant who is determined by the Department to be eligible for services under the children's waivers may elect not to use waiver services, but may choose admission to an ICF/ID.~~ (7-1-11)
- 05. ~~Home and Community Based Waiver Participant Limitations.~~** ~~The number of Medicaid participants to receive waiver services under the children's waivers for participants with developmental disabilities will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after June 30th of each new waiver year.~~ (7-1-11)
- 683. ~~Children's Waiver Services: Coverage And Limitations.~~** ~~All children's DD waiver services must be identified on a plan of service developed by the family-centered planning team, and must be recommended by a physician or other practitioner of the healing arts. In addition to the children's home and community-based state plan option services described in Section 663 of these rules, the following services are available for waiver-eligible participants and are reimbursable services when provided in accordance with these rules:~~ (7-1-16)
- 01. ~~Family Training.~~** ~~Family training is professional one-on-one (1 on 1) instruction to families to help them better meet the needs of the waiver participant receiving intervention services.~~ (7-1-11)

~~a. Family training is limited to training in the implementation of intervention techniques as outlined in the plan of service. (7-1-11)~~

~~b. Family training must be provided to the participant's parent or legal guardian when the participant is present. (7-1-11)~~

~~c. The family training provider must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. (7-1-11)~~

~~d. The parent or legal guardian of the waiver participant is required to participate in family training when the participant is receiving habilitative interventions. The following applies for each waiver program: (7-1-11)~~

~~i. For participants enrolled in the Children's DD Waiver, the amount, duration, and frequency of the training must be determined by the family-centered planning team and the parent or legal guardian, and must be listed as a service on the plan of service. (7-1-11)~~

~~ii. For participants enrolled in the Act Early Waiver, the parent or legal guardian will be required to be present and actively participate during the intervention service session for at least twenty percent (20%) of the intervention time provided to the child. (7-1-11)~~

~~**02. Interdisciplinary Training.** Interdisciplinary training is professional instruction to the direct service provider. Interdisciplinary training must only be provided during the provision of a support or intervention service. Interdisciplinary training is provided to assist the direct provider to meet the needs of the waiver participant. (7-1-11)~~

~~a. Interdisciplinary training includes: (7-1-11)~~

~~i. Health and medication monitoring; (7-1-11)~~

~~ii. Positioning and transfer; (7-1-11)~~

~~iii. Intervention techniques; (7-1-11)~~

~~iv. Positive Behavior Support; (7-1-11)~~

~~v. Use of equipment; (7-1-11)~~

~~b. Interdisciplinary training must only be provided to the direct service provider when the participant is present. (7-1-11)~~

~~c. The interdisciplinary training provider must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. (7-1-11)~~

~~d. Interdisciplinary training between a habilitative interventionist and a therapeutic consultant is not a reimbursable service. (7-1-11)~~

~~e. Interdisciplinary training between employees of the same discipline is not a reimbursable service. (7-1-11)~~

~~**03. Habilitative Intervention Evaluation.** The purpose of the habilitative intervention evaluation is to guide the formation of developmentally appropriate objectives and intervention strategies related to goals identified through the family-centered planning process. The habilitative interventionist must complete an evaluation prior to the initial provision of habilitative intervention services. The evaluation must include: (7-1-11)~~

~~a. Specific skills assessments for deficit areas identified through the eligibility assessment; (7-1-11)~~

~~b. Functional behavioral analysis; (7-1-11)~~

- e. ~~Review of all assessments and relevant histories provided by the plan developer; and~~ (7-1-11)
 - d. ~~Clinical Opinion. Professional summary that interprets and integrates the results of the testing. This summary includes functional, developmentally appropriate recommendations to guide treatment.~~ (7-1-11)
- ~~**04. Habilitative Intervention.** Habilitative intervention services must be consistent, aggressive, and continuous and are provided to improve a child's functional skills and minimize problem behavior. Services include individual or group behavioral interventions and skill development activity. Habilitative intervention must be based upon the well-known and widely regarded principles of evidence-based treatment. Evidence-based treatment (EBT) refers to the use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems. As "promising practices" meet statistically significant effectiveness, they could be included as approved approaches.~~ (7-1-11)
- a. ~~Habilitative intervention must be provided to meet the intervention needs of the participant by developing adaptive skills for all participants, and addressing maladaptive behaviors for participants who exhibit them.~~ (7-1-11)
 - i. ~~When goals to address maladaptive behavior are identified on the plan of service, the intervention must include the development of replacement behavior rather than merely the elimination or suppression of maladaptive behavior that interferes with the child's overall general development, community, and social participation.~~ (7-1-11)
 - ii. ~~When goals to address skill development are identified on the plan of service, the intervention must provide for the acquisition of skills that are functional.~~ (7-1-11)
 - b. ~~Habilitative intervention must be provided in the participant's home or community setting, and in addition may be provided in a center-based setting.~~ (7-1-11)
 - e. ~~Group intervention may be provided in the community and center. When habilitative intervention is provided as group intervention, the following applies:~~ (7-1-11)
 - i. ~~There must be a minimum of one (1) qualified staff providing direct services for every three (3) participants. As the number and severity of the participants with functional impairments or behavioral issues increases, the staff participant ratio must be adjusted accordingly.~~ (7-1-11)
 - ii. ~~When group intervention is community-based, the child must be integrated in the community in a natural setting with typically developing peers.~~ (7-1-11)
 - iii. ~~Group intervention must be directly related to meeting the needs of the child, and be identified as an objective in accordance with a plan of service goal.~~ (7-1-11)
- ~~**05. Therapeutic Consultation.** Therapeutic consultation provides a higher level of expertise and experience to support participants who exhibit severe aggression, self injury, and other dangerous behaviors. Therapeutic consultation is provided when a participant receiving habilitative intervention has been assessed as requiring a more advanced level of training and assistance based on the participant's complex needs. A participant requires therapeutic consultation when interventions are not demonstrating outcomes and it is anticipated that a crisis event may occur without the consultation service.~~ (7-1-11)
- a. ~~The therapeutic consultant assists the habilitative interventionist by:~~ (7-1-11)
 - i. ~~Performing advanced assessments as necessary;~~ (7-1-11)
 - ii. ~~Developing and overseeing the implementation of a positive behavior support plan;~~ (7-1-11)
 - iii. ~~Monitoring the progress and coordinating the implementation of the positive behavioral support plan across environments; and~~ (7-1-11)

- iv. ~~Providing consultation to other service providers and families. (7-1-11)~~
- ~~b. Telehealth resources may be used by a therapeutic consultant to provide consultation as appropriate and necessary. (7-1-11)~~
- ~~e. Therapeutic consultation providers are subject to the following limitations: (7-1-11)~~
 - i. ~~Therapeutic consultation cannot be provided as a direct intervention service. (7-1-11)~~
 - ii. ~~Participants must be receiving rehabilitative intervention services prior to accessing therapeutic consultation, with the exception of crisis situations. (7-1-11)~~
 - iii. ~~Therapeutic consultation is limited to eighteen (18) hours per year per participant. (7-1-11)~~
 - iv. ~~Therapeutic consultation must be prior authorized by the Department. (7-1-11)~~
- ~~06. **Crisis Intervention.** Crisis intervention services provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. The need for crisis intervention must meet the definition of crisis in Section 681 of these rules. This service may provide training and staff development related to the needs of a participant, and also provides emergency back-up involving the direct support of the participant in crisis. Children's crisis intervention services: (7-1-11)~~
 - ~~a. Are provided in the home and community. (7-1-11)~~
 - ~~b. Are provided on a short term basis typically not to exceed thirty (30) days. (7-1-11)~~
 - ~~c. Cannot exceed fourteen (14) days of out-of-home placement. (7-1-11)~~
 - ~~d. Must be prior authorized by the Department. (7-1-11)~~
 - i. ~~Authorization for crisis intervention may be requested retroactively as a result of a crisis, defined in Section 681 of these rules, when no other means of support is available to the participant. In retroactive authorizations, the crisis intervention provider must submit a request for crisis intervention to the Department within seventy two (72) hours of providing the service. (7-1-11)~~
 - ii. ~~If staying in the home endangers the health and safety of the participant, the family, or both, the provider may request short term out of home placement for the participant. Out of home placement must be prior authorized by the Department. (7-1-11)~~
 - ~~e. Must use positive behavior interventions prior to and in conjunction with the implementation of any restrictive intervention. (7-1-11)~~
 - ~~f. Telehealth resources may be used by a crisis interventionist to provide consultation in a crisis situation. (7-1-11)~~
- ~~07. **Family Directed Community Supports.** Families of participants eligible for the children's DD waiver may choose to direct their individualized budget rather than receive the traditional services described in Subsections 683.01 through 683.06 of this rule when the participant lives at home with the parent or legal guardian. The requirements for selecting and participating in this option are outlined in IDAPA 16.03.13 "Consumer Directed Services." Act Early Waiver participants do not have the option to choose the family directed services path. The Act Early Waiver is intended to be a more structured program that requires increased involvement from families, and ensures children receive an intense amount of services based on evidence based research. (7-1-11)~~
- ~~08. **Service limitations.** Children's waiver services are subject to the following limitations: (7-1-11)~~
 - ~~a. Place of Service Delivery. Waiver services may be provided in the participant's personal residence,~~

~~community, or DDA. The following living situations are specifically excluded as a place of service for waiver services: (7-1-11)~~

~~i. Licensed skilled or intermediate care facilities, certified nursing facility (NF) or hospital; and (7-1-11)~~

~~ii. Licensed Intermediate Care Facility for persons with Intellectual Disabilities (ICF/ID); and (7-1-11)~~

~~iii. Residential Care or Assisted Living Facility; (7-1-11)~~

~~iv. Additional limitations to specific services are listed under that service definition. (7-1-11)~~

~~b. According to 42 CFR 440.180, Medicaid Waiver services cannot be used to pay for special education and related services that are included in a child's Individual Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA), that are otherwise available through a local educational agency. (7-1-11)~~

~~c. Children's waiver services are limited by the participant's individualized budget amount, excluding crisis intervention. (7-1-11)~~

~~d. For the children's waiver services listed in Subsections 683.01 through 683.07 of these rules, the following are excluded for Medicaid payment: (7-1-11)~~

~~i. Vocational services; (7-1-11)~~

~~ii. Educational services; and (7-1-11)~~

~~iii. Recreational services. (7-1-11)~~

~~684. Children's Waiver Services: Procedural Requirements.~~

~~01. Authorization of Services on a Written Plan. All children's waiver services must be identified on the plan of service and authorized by the Department. The plan of service must be reviewed by a plan developer at least every six (6) months or at a frequency determined by the family-centered planning team. (7-1-11)~~

~~02. General Requirements for Program Documentation. Children's waiver providers must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. For each participant the following program documentation is required: (7-1-11)~~

~~a. Direct service provider information which includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information: (7-1-11)~~

~~i. Date and time of visit; and (7-1-11)~~

~~ii. Services provided during the visit; and (7-1-11)~~

~~iii. A statement of the participant's response to the service, including any changes in the participant's condition; and (7-1-11)~~

~~iv. Length of visit, including time in and time out; and (7-1-11)~~

~~v. Specific place of service. (7-1-11)~~

~~b. A copy of the above information must be maintained by the independent provider or DDA. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (7-1-18)~~

~~**03. Program Implementation Plan Requirements.** For each participant receiving intervention and family training services, the DDA must develop a program implementation plan to determine objectives to be included on the participant's required plan of service. (7-1-18)~~

~~**a.** All program implementation plan objectives must be related to a goal on the participant's plan of service. (7-1-11)~~

~~**b.** The program implementation plan must be written, implemented, and submitted to the plan developer within fourteen (14) days after the first day of ongoing programming and be revised whenever participant needs change. If the program implementation plan is not completed within this time frame, the participant's records must contain documented participant-based justification for the delay. (7-1-13)~~

~~**c.** The program implementation plan must be completed by the habilitative interventionist, and must include the following requirements: (7-1-11)~~

~~**i.** The participant's name. (7-1-11)~~

~~**ii.** A baseline statement. (7-1-11)~~

~~**iii.** Measurable, behaviorally-stated objectives that correspond to those goals or objectives previously identified on the required plan of service. (7-1-11)~~

~~**iv.** Written instructions to the staff that may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. (7-1-11)~~

~~**v.** Identification of the type of environment(s) and specific location(s) where services will be provided. (7-1-11)~~

~~**vi.** A description of the evidence-based treatment approach used for the service provided. (7-1-11)~~

~~**vii.** When the child has a current positive behavior support plan, it must be incorporated into the program implementation plan. (7-1-11)~~

~~**viii.** When interdisciplinary training is provided, identification of the type of interdisciplinary training and the objectives related to the training must be included on the program implementation plan. (7-1-11)~~

~~**ix.** Target date for completion, not to exceed one (1) year. (7-1-11)~~

~~**x.** The program implementation plan must be reviewed and approved by the clinical supervisor, as indicated by signature, credential, and date on the plan. (7-1-13)~~

~~**04. Reporting Requirements.** The clinical supervisor must complete, at a minimum, six (6) month and annual provider status reviews for habilitative intervention and family training services provided. These provider status reviews must be completed more frequently when so required on the plan of service. (7-1-11)~~

~~**a.** Documentation of the six (6) month and annual reviews must be submitted to the plan developer. (7-1-11)~~

~~**b.** The provider must use Department-approved forms for provider status reviews. (7-1-11)~~

~~**05. Provider Responsibility for Notification.** It is the responsibility of the service provider to notify the plan developer when any significant changes in the participant's condition, as defined by the family-centered planning team, are noted during service delivery. Such notification will be documented in the service record. (7-1-11)~~

~~06. **Records Maintenance.** 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. (7-1-11)~~

~~685. **Children's Waiver Services: Provider Qualifications And Duties.**~~

~~01. **Family Training.** Providers of family training must meet the requirements for habilitative intervention providers defined in Subsections 685.03 and 685.04 of this rule. (7-1-11)~~

~~02. **Interdisciplinary Training.** Providers of interdisciplinary training must meet the following requirements: (7-1-11)~~

~~a. Occupational Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)~~

~~b. Physical Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)~~

~~c. Speech-Language Pathologist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)~~

~~d. Practitioner of the healing arts; (7-1-11)~~

~~e. Habilitative intervention provider as defined in Subsections 685.03 and 685.04 of this rule; or (7-1-11)~~

~~f. Therapeutic consultation provider as defined in Subsection 685.05 of this rule. (7-1-11)~~

~~03. **Habilitative Intervention.** Habilitative intervention must be provided by a DDA certified to provide both support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." The DDA must be capable of supervising the direct services provided. Providers of habilitative intervention must meet the following minimum qualifications: (7-1-11)~~

~~a. Must hold at least a bachelor's degree in a human services field from a nationally accredited university or college; (7-1-11)~~

~~b. Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. Experience must be gained through paid employment or university practicum experience or internship; (7-1-11)~~

~~c. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative intervention; or (7-1-11)~~

~~d. Individuals working as Developmental Specialists for children age birth through three (3) or three (3) through 17, and individuals certified as Intensive Behavioral Intervention professionals prior to July 1, 2011, are qualified to provide habilitative intervention until June 30, 2013. The individual must meet the requirements of the Department approved competency coursework by June 30, 2013 to maintain his certification. (7-1-11)~~

~~04. **Habilitative Intervention for Children Birth to Three.** In addition to the habilitative intervention qualifications listed in Subsections 685.03.a. through d. of this rule, habilitative intervention staff serving infants and toddlers from birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally supervised experience with young children who have developmental disabilities and one (1) of the following: (7-1-11)~~

~~a. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or (7-1-11)~~

- ~~b. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or (7-1-11)~~
- ~~e. A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: (7-1-11)~~
 - ~~i. Promotion of development and learning for children from birth to three (3) years; (7-1-11)~~
 - ~~ii. Assessment and observation methods for developmentally appropriate assessment of young children; (7-1-11)~~
 - ~~iii. Building family and community relationships to support early interventions; (7-1-11)~~
 - ~~iv. Development of appropriate curriculum for young children, including IFSP and IEP development; (7-1-11)~~
 - ~~v. Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and (7-1-11)~~
 - ~~vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-11)~~
- ~~d. Electives closely related to the content under Subsection 685.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education. (7-1-11)~~
- ~~e. Developmental specialists who possess a bachelor's or master's degree listed above under Subsection 685.04.c.ii. of this rule, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement. (7-1-11)~~
- ~~f. When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: (7-1-11)~~
 - ~~i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. (7-1-11)~~
 - ~~ii. Satisfactory progress will be determined on an annual review by the Department. (7-1-11)~~
 - ~~iii. Individuals who have an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as they demonstrate satisfactory progress on the plan and complete the requirements on the plan within three (3) years of their date of hire. (7-1-11)~~
- ~~05. **Therapeutic Consultation.** Therapeutic consultation may be provided by a DDA certified to provide both supports and intervention services under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," or by an independent Medicaid provider under agreement with the Department. Providers of therapeutic consultation must meet the following minimum qualifications: (7-1-18)~~
 - ~~a. Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and (7-1-11)~~

~~b. Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior. (7-1-11)~~

~~c. Therapeutic consultation 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." (7-1-11)~~

~~d. Therapeutic consultation providers employed by a DDA must be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21 "Developmental Disabilities Services (DDA)." Independent therapeutic consultation providers must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter. (7-1-18)~~

~~06. **Crisis Intervention.** Crisis intervention may be provided by a DDA certified to provide support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," by an independent Medicaid provider under agreement with the Department. Providers of crisis intervention must meet the following minimum qualifications: (7-1-18)~~

~~a. Crisis Intervention professionals must meet the minimum therapeutic consultation provider qualifications described in Subsection 685.05 of this rule. (7-1-11)~~

~~b. Emergency intervention technician providers must meet the minimum habilitative support provider qualifications described under Subsection 665.02 of these rules. (7-1-11)~~

~~c. Crisis intervention 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." (7-1-11)~~

~~07. **Continuing Training Requirements for Professionals.** Each professional providing waiver services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. If the individual has not completed the required training during any yearly training period, he may not provide waiver services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period. (7-1-11)~~

~~08. **Requirements for Clinical Supervision.** All DD services must be provided under the supervision of a clinical supervisor. The clinical supervisor must meet the qualifications to provide habilitative intervention as defined in this rule. Clinical supervisor(s) are professionals employed by a DDA on a continuous and regularly scheduled basis. (7-1-18)~~

~~a. The clinical supervisor is responsible for the oversight and supervision of service and support elements of the agency, including face-to-face supervision of agency staff providing direct services. (7-1-11)~~

~~b. The clinical supervisor must observe and review the direct services performed by all paraprofessional and professional staff on a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the services and support. (7-1-11)~~

~~c. Each DDA must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction. (7-1-18)~~

~~09. **Requirements for Collaboration with Other Providers.** Providers of waiver services must coordinate with the family-centered planning team as specified on the plan of service. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra indicated or delivered in a manner that presents a risk to the participant's mental health status. (3-20-14)~~

~~10. **Requirements for Quality Assurance.** Providers of children's waiver services must demonstrate high quality of services, including treatment fidelity, through an internal quality assurance review process. (7-1-11)~~

~~11. **DDA Services.** In order for a DDA to provide waiver services, the DDA must be certified to provide both support and intervention services. Each DDA is required to provide habilitative supports. When a DDA opts to provide habilitative intervention services, the DDA must also provide habilitative supports and family training. (7-1-11)~~

~~686. **Children's Waiver Services: Provider Reimbursement.**~~

~~01. **Reimbursement.** The statewide reimbursement rate for children's HCBS state plan option services listed in Subsections 683.01 through 683.06 of these rules was derived by using Bureau of Labor Statistics mean wage for the direct care staff providing the service, adjusted for employment related expenditures, program related costs, and general and administrative costs based on a cost survey as described in Subsection 686.02 of this rule. Reimbursement rates are set at a percentage of the statewide target reimbursement rate. The Department will take into consideration the factors of efficiency, economy, quality of care, and access to care when determining rates. (7-1-11)~~

~~02. **Cost Survey.** The Department will conduct a cost survey every five (5) years from a statistically appropriate number of provider association representatives in order to obtain cost data for employment related expenditures, program related costs, and general and administrative costs. (7-1-11)~~

~~03. **Claim Forms.** Provider claims for payment will be submitted on claim forms provided by or approved by the Department. Billing instructions will be provided by the Department. (7-1-11)~~

~~04. **Rates.** The reimbursement rates calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation. (7-1-11)~~