

**IDAPA 16  
TITLE 03  
CHAPTER 10**

**16.03.10 – MEDICAID ENHANCED PLAN BENEFITS**

**SUB-PART: CHILDREN’S DEVELOPMENTAL DISABILITIES (DD) HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN OPTION**

(Sections 520 - 528)

**520. CHILDREN’S DD HCBS STATE PLAN OPTION.**

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. (7-1-19)T

**521. 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. (7-1-19)T

**01. Annual.** Every three hundred sixty-five (365) days, except during a leap year which equals three hundred sixty-six (366) days. (7-1-19)T

**02. Community.** Natural, integrated environments outside of the participant’s home, ~~school, or~~ outside of DDA center-based settings, or at school outside of school hours. (7-1-19)T

**03. Developmental Disabilities Agency (DDA).** (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

**04. 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. (7-1-16)

**05. Family-Centered Planning Team.** The planning group who helps inform the participant about available services in order to develop the participant’s plan of service. This group includes, at a minimum, the 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.~~ (7-1-19)T

**06. ~~Home and Community-Based Services State~~ (HCBS) State 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 participants with disabilities, ~~without determining that who~~ without the provision of services the participants would require institutional level of care. (7-1-19)T

**07. Integration.** 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. (7-1-19)T

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

**09. 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 participants 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. (7-1-19)T

**10. 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 must cover all services and supports identified during the family-centered planning process and must meet the HCBS person-centered plan requirements as described in Section 317 of these rules. (7-1-19)T

**11. 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)

**12. 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 that were determined through a family-centered planning process. ~~The plan~~ 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. (7-1-19)T

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

**14. 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 described in Sections 520 through 528 of these rules. (7-1-19)T

**15. 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)

**16. 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)

**17. 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)

**18. 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 individual's needs for services and supports as identified in the assessment. (7-1-11)

**19. 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)

**20. Supervisor.** ~~For the purposes of these rules, the supervisor is the~~ An individual responsible for the supervision of DDA staff or independent providers and must meet the intervention specialist or professional qualifications as outlined in IDAPA 16.03.09, "Children's Habilitation Intervention Services." (7-1-19)T

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

## **522. CHILDREN'S DD HCBS STATE PLAN OPTION: ELIGIBILITY DETERMINATION.**

~~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 a participant's eligibility will be made by the Department. (7-1-19)T

**01. Initial Eligibility Assessment Developmental Disability Determination.** The Department, or its contractor, will determine if a child meets established criteria for a developmental disability by completing the following: (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 assessment (MSDA) summary. (7-1-19)T

**02. Determination for Children's DD HCBS Home and Community-Based State Plan Option.** The Department, or its contractor, will determine if a child meets the established criteria necessary to receive children's DD HCBS home and community-based state plan option services by verifying: (7-1-19)T

- a. The participant is birth through seventeen (17) years of age; and (7-1-19)T
- b. The participant has a developmental disability as defined under Sections 500, 501, and 503 these rules and Section 66-402, Idaho Code, and has a demonstrated need for Children's DD HCBS state plan option services; and (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. Individualized Budget Methodology.** The following four (4) categories are used when determining individualized budgets for children with developmental disabilities. (7-1-19)T

- a. Children's DD - Level I. Children meeting developmental disabilities criteria. (7-1-19)T
- b. Children's DD - Level II. (7-1-19)T
  - i. Children who qualify based on functional limitations when their composite full-scale standard score of less than fifty (50); or (7-1-19)T
  - ii. 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. (7-1-19)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. Participant Notification of Budget Amount.** The Department, or its contractor, notifies will notify 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. (7-1-19)T

**05. Annual Re-Evaluation.** 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. (7-1-19)T

### 523. CHILDREN'S DD HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.

All children's DD HCBS 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 in the group must be adjusted from three (3) to two (2), 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; (7-1-19)T

and ii. The independent respite provider is delivering respite to no more than three (3) eligible siblings; (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~~ 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. 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 by providing an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to the participant's diagnoses. 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 ~~DD HCBS 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 523.03~~4~~ of this rule when the participant lives at home with ~~his~~ their 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 Additional requirements for this option are outlined in Sections 520 through 522, Subsections 523.05-06, 524.01-03, 523-06, 524.07-10, and 525.01, and Section 528, of these rules, and IDAPA 16.03.13, "Consumer-Directed Services." (7-1-19)T

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

- a. Children's DD 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 ~~DD 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 ~~DD HCBS~~ ~~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 DD HCBS STATE PLAN OPTION: PLAN OF SERVICE PROCESS.**

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. (7-1-19)T

**01. History and Physical.** 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. (7-1-19)T

**02. Plan of Service Development.** 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. (7-1-19)T

**03. Requirements for Collaboration.** Providers of ~~children's DD HCBS 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~~ ~~services~~, ~~identifying~~ any barriers to services, and ~~making any necessary~~ changes to the plan of service ~~if needed~~. (7-1-19)T

**05. Provider Status Reviews.** The service providers identified in ~~Subsection 523.03~~ ~~526~~ 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~~ ~~The annual~~ 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)T

**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 DD HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS.

**01. Requirements for Prior Authorization.** 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. (7-1-19)T

**02. Requirements for Supervision.** All ~~children's DD HCBS provided by a DDA or independent provider support services~~ must be ~~supervised provided under supervision~~. The supervisor must meet the ~~intervention specialist or professional~~ 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. (7-1-19)T

**03. Requirements for Quality Assurance.** Providers of children's ~~DD HCBS home and community-based~~ state plan option ~~services~~ must demonstrate high quality of services through an internal quality assurance review process. (7-1-19)T

**04. 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.~~ 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: (7-1-19)T

- a. Date and time of visit; (7-1-19)T
- b. Support services provided during the visit; (7-1-19)T
- c. ~~A summary of session or services provided; 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 or independent provider 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 DD HCBS STATE PLAN OPTION: PROVIDER QUALIFICATIONS AND DUTIES.** All providers of children's DD HCBS state plan option services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (7-1-19)T

**01. Respite.** 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: (7-1-19)T

- a. Be at least sixteen (16) years of age when employed by a DDA; or (7-1-19)T  
b. 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 independent respite provider; and (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~~  
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 satisfactorily complete a criminal history background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks,"; and (7-1-19)T  
f. 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. Community-Based Support.** Community-based supports ~~must may~~ be provided by ~~an agency certified as a DDA or an independent provider. An independent provider is an individual who has entered into a provider agreement with the Department. with staff who are capable of supervising the direct services provided.~~ Providers of community-based supports must meet the following minimum qualifications: (7-1-19)T

- a. ~~Must be~~ Be at least eighteen (18) years of age; (7-1-19)T  
~~b. Must be at least eighteen (18) years of age; (7-1-19)T~~  
c. Have received instructions in the needs of the participant who will be provided the service; (7-1-19)T  
c. Demonstrate the ability to provide services according to a plan of service; (7-1-19)T  
d. Must have 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
- e. ~~Must complete~~ **Complete** competency coursework approved by the Department to demonstrate competencies related to the requirements to provide community-based supports. (7-1-19)T
- f. 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, be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." Independent providers must be certified in CPR and first aid prior to delivering services and must maintain current certification thereafter. (7-1-19)T

**03. Family Education.** 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 and meets the intervention specialist or professional qualifications as outlined in IDAPA 16.03.09, "Children's Habilitation Intervention Services." ~~in one (1) of the following: Providers of Family Education must meet one (1) of the following minimum qualifications:~~ (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;~~ (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;~~ (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

## **527. 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. (7-1-19)T

~~**01. Reimbursement.** 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.~~ (7-1-19)T

~~**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.~~ (7-1-19)T

**01. 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. (7-1-19)T

**02. 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 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.** 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. (7-1-19)T

**02. Quality Improvement.** Quality improvement consists of the Department working with the provider to resolve identified issues and enhance services provided. Quality improvement activities must include: (7-1-19)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. Corrective Action.** 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: (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