March 2019 Collaborative Rule Making Meeting

Introductions and Basic Overview

- Process
- Overview of Last Meetings
- Not in Chronological Order
- "Department Approved"

Ground Rules

- Avoid repeat questions
- Everyone has a right to be heard
- Strive for solution focused comments
- Be specific
- Be respectful
- Not every comment will be responded to today but they will be responded to and posted to web

16.03.10 → 16.03.09

- Rules related to Intervention Services in 16.03.10 have been moved to 16.03.09
  - Definitions
  - Provider Qualifications
  - Prior Authorization
  - Documentation Requirements

Definitions

16.03.10.521 Definitions

~~**Human Services Field.** A particular area of academic study in that includes, but is not limited to, sociology, special education, rehabilitation counseling, and psychology as described in 42 CFR § 483.430(b)(5)(x).~~

~~**Professional**. A person qualified to provide family education services.~~

~~**Family.** The participant and his parent or decision-making authority.~~

~~**Child.** A person who is under the age of eighteen (18) years.~~

16.03.10.521 Definitions

21. Supervisor. 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."

22. Support Services. Support services that provide supervisor and assistance to an individual or facilitates integration into the community.

Supports Services

All supports services will remain in the 16.03.10 rule set. This includes:

- Community-Based Supports (formerly Habilitative Supports)
- Respite care
- Family Education
- Supports services delivered through the Family Directed model
- Adolescent respite is also being added as a new service.

Rule Shifts

- 1915 (c) Waiver's Going Away
  - Children's DD
  - Act Early
- Intervention Services moved to 16.03.09
- Opportunity to Simplify 16.03.10
- Opportunity to Revise for Language Consistency 16.03.10

Services

16.03.10.523 Children's DD HCBS State Plan Option Coverage and Limitations

523. 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.

16.03.10.523 Coverage and Limitations Community-Based Supports

03. Community-Based Supports. Community-Based Supports provides assistance to an individual with a disability by facilitating the individual's independence and integration into the community. This service provides an opportunity for individuals to explore their interests, practice skills learned in other therapeutic environments, and learn through interactions in typical community activities. Integration into the community enables individuals 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.

16.03.10.523.03 Community-Based Supports

Community-Based Supports must:

a. Not supplant services provided in school or therapy, or supplant the role of the primary caregiver;

b. Ensure the individual is involved in age-appropriate activities and is engaging with typical peers according to the ability of the individual; and

c. Have a minimum of one (1) qualified staff providing direct services to every two (2) or three (3) participants when provided as group community-Based supports. As the number and severity of the participants with functional impairments increases, the staff participant ratio shall be adjusted accordingly.

16.03.10.523.01 Respite

01. Respite. Respite provides supervision to the individual 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 (Developmental Disability Agency - DDA) or by an independent respite provider. An independent respite provider may be a relative of the child. Payment for respite is not made for room and board. Respite may be provided in the individual's home, the private home of the Independent Respite Provider, a DDA, or in the community.

16.03.10.523.01 Respite (cont.)

The following limitations apply.

a. Respite must not be provided on a continuous, long-term basis as a daily service that would enable an unpaid caregiver to work.
b. Respite must only be offered to individuals living with an unpaid caregiver who requires relief.
c. Respite cannot exceed fourteen (14) consecutive days.
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.

16.03.10.523.01 Respite (cont.)

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.

16.03.10.523.01 Respite (cont.)

f. When Respite is provided as group Respite, the following applies:

   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 issues increases, the staff-to-participant ratio must be adjusted accordingly.

   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.

16.03.10.523.01 Respite (cont.)

g. Respite cannot be provided as center-based by an Independent Respite Provider. An Independent Respite Provider can provide group respite when the following are met:

   i. The Independent Respite Provider is a relative; and

   ii. Is delivering Respite to no more than three eligible(3) siblings; and

   iii. The service is delivered in the home of the participants or the Independent Respite Provider.

16.03.10.523.02 Adolescent Respite

02. Adolescent Respite. Adolescent Respite is a supervision support service provided to individuals ages 12 and older with a developmental disability. Adolescent Respite may be used afterschool or on days when school is not in session to support the individual while the unpaid caregiver is working. Limitations to Respite as defined in IDAPA 16.03.10.523.01.b-g are also applicable to Adolescent Respite.

16.03.10.523.04
Family Education

04. Family Education. Family education is professional assistance to family members to help them better meet the needs of the individual. It offers education that 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 the individual's diagnoses.

16.03.10.523.04
Family Education (cont.)

a. Family Education providers must maintain documentation of the training in the individual's record documenting the provision of activities outlined in the plan of service.
b. Family Education may be provided in a group setting not to exceed five (5) individuals' families.

16.03.10.523.05 Family-Directed Community Supports

05. Family-Directed Community Supports (FDCS). Families of individuals 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 individual 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 this rule and IDAPA 16.03.13 "Consumer-Directed Services."

16.03.10.523.06 Limitations

a. HCBS state plan option services are limited by the participant's individualized budget amount.

b. Services offered in IDAPA 16.03.09 "Medicaid Basic Plan Benefits" may not be authorized under these rules.

16.03.10.523.06 Limitations

c. Duplication of services cannot be provided. Services are considered duplicate when:

i. An adaptive equipment and support service address the same goal; or

ii. Multiple adaptive equipment items address the same goal; or

iii. Goals are not separate and unique to each service provided; or

iv. When more than one service is provided at the same time, unless otherwise authorized.

16.03.10.523.06 Limitations

d. For the children's HCBS state plan option services listed in Subsections 523.01, 523.02, and 523.03, the following are excluded for Medicaid payment:

i. Vocational services; and

ii. Educational services; and

iii. Recreational services.

16.03.10.523
Coverage and Limitations

07. 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.

Submit Comments Now

Provider Qualifications

16.03.10.526
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.

16.03.10.526.02
Provider Qualifications and Duties

02. Community-Based Support. 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:

a. Must be at least eighteen (18) years of age;

b. Must be a high school graduate or have a GED;

c. Have received instructions in the needs of the participant who will be provided the service;

d. Demonstrate the ability to provide services according to a plan of service;

16.03.10.526
Provider Qualifications and Duties (Community-Based Support cont.)

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

i. Have previous work experience gained through paid employment, university practicum experience, or internship; or

ii. Have on-the-job supervised experience gained through employment at a DDA with increased supervision. 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.

iii. For individuals providing Community-Based Supports to children age birth to three (3) the six (6) months of documented experience must be with infants, toddlers or children birth to three (3) years of age with developmental delays or disabilities.

16.03.10.526
Provider Qualifications and Duties (cont.)

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 in one of the following. Providers of Family Education must meet the following minimum qualifications:

a. Must meet the qualifications of an Intervention Specialist, as defined IDAPA 16.03.09.575.02; or

b. Meet the minimum qualifications of Intervention Professional, as outlined in IDAPA 16.03.09.575.03; or

16.03.10.526
Provider Qualifications and Duties (cont.)

c. Meet the minimum qualifications to provide services under a Department approved Evidence Based Model Intervention Specialist, as outlined in IDAPA 16.03.09.575.05; or

d. Meet the minimum qualifications to provide services under a Department approved Evidence Based Model Intervention Professional, as outlined in IDAPA 16.03.09.575.06.

16.03.10.526
Provider Qualifications and Duties (cont.)

01. Respite. Respite services 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 services must meet the following minimum qualifications:

16.03.10.526
Provider Qualifications and Duties (cont.)

a. Must be at least sixteen (16) years of age when employed by a DDA; or

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

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

16.03.10.526
Provider Qualifications and Duties (cont.)

d. Have received instructions in the needs of the participant who will be provided the service; and

e. Demonstrate the ability to provide services according to a plan of service; and

f. Must satisfactorily complete a criminal history background check in accordance with IDAPA 16.05.06 "Criminal History and Background Checks"; and

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.

Submit Comments Now

Procedural Requirements

16.03.10.525
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 individuals' 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 317of 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 individual's decision-making authority, the provider agency responsible for service provision, and has been authorized by the Department.

16.03.10.525
Procedural Requirements

02. Requirements for Supervision. All DDA support services must be provided under the supervision of a supervisor. The supervisor must meet the qualifications as outlined in IDAPA 16.03.09.575.02-07.

a. 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.

03. Requirements for Quality Assurance. Providers of children's home and community-based state plan option service must demonstrate high quality of services through an internal quality assurance review process.

16.03.10.525
Procedural Requirements

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 of DDA in accordance with IDAPA 16.05.07.101. 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:

16.03.10.525.04 Procedural Requirements (cont)

a. Date and time of visit; and
b. Support services provided during the visit; and
c. A statement of the participant's response to the service; and
d. Length of visit, including time in and time out; and
e. Location of service; and
f. Signature of the individual providing the service and date signed.

16.03.10.525
Procedural Requirements (cont)

05. Community-Based Supports Documentation. In addition to the general requirements listed in Subsection 525.04 of this rule, the following must be completed:

a. On a monthly basis, the Community-Based Supports staff must complete a summary of the participant's response to the support service and submit the monthly summary to the supervisor.

16.03.10.525
Procedural Requirements (cont)

b. The 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.

i. 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 so required on the plan of service.

ii. Documentation of the six- (6) month and annual reviews must be submitted to the plan monitor.

iii. The provider must use Department-approved forms for provider status reviews

Submit Comments Now

Eligibility Determination

16.03.10.522
Children's DD HCBS State Plan Option: Eligibility Determination

Prior to receiving Children's DD HCBS State Plan Option services as provided in Section 523 of these rules, the individual 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 individual's eligibility will be made by the Department.

16.03.10.522
Eligibility Determination

01. Developmental Disability Determination. The Department or its contractor will determine if a child meets established criteria for a developmental disability by completing the following:

a. Documentation of an individual's developmental disability diagnosis, demonstrated by:

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

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 individuals whose eligibility is based on developmental disabilities other than intellectual disability.

16.03.10.522
Eligibility Determination

b. A functional assessment that reflects the individual'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 individual's level of care criteria and must be completed sixty (60) calendar days before the expiration of the current plan of service.

c. Medical, Social, and Developmental Summary

16.03.10.522
Eligibility Determination

02. Determination for Children's 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 home and community-based state plan option services by verifying:.

a. The individual is birth through seventeen (17) years of age; and

b. The individual 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

c. The individual 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.

16.03.10.522
Eligibility Determination

01. Individualized Budget Methodology. The following four (4) categories are used when determining individualized budgets for children with developmental disabilities:

a. Children's DD – Level I

b. Children's DD - Level II

c. Children's DD – Level III

d. Children's DD – Level IV. 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.

16.03.10.522
Eligibility Determination

04. Participant Notification of Budget Amount. The Department or its contractor notifies each individual of his set budget amount as part of the eligibility determination process. The notification will include how the individual may appeal the budget amount.

05. Annual Re-evaluation. Individualized budgets will be re-evaluated annually. At the request of the individual, 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.

Plan of Service Process

16.03.10.524
Plan of Service Process

CHILDREN'S DD HCBS STATE PLAN OPTION: PLAN OF SERVICE PROCESS. In collaboration with the participant, the Department must ensure that the individual 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 individual meet desired goals. Paid plan development must be provided by the Department or its contractor in accordance with Section 316 of these rules.

16.03.10.524
Plan of Service Process

01. History and Physical. Prior to the development of the plan of service, the plan developer will 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 must conduct the history and physical and may refer the participant for other evaluations.

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.

16.03.10.524
Plan of Service Process

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.

16.03.10.524
Plan of Service Process

05. Provider Status Reviews. The service providers identified in Section 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.

16.03.10.524
Plan of Service Process

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/decision making authority. 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.

Provider Reimbursement

Rate Methodology

- 16.03.10.666.01 – 04 = Children's HCBS State Plan Option: Provider Reimbursement
- 16.03.10.686.01 – 04 = Children's Waiver Services: Provider Reimbursement
- Section 686 deleted; section 666 moved to section 527

Submit Comments Now

Quality Assurance and Improvement Processes

16.03.10.528 Quality Assurance and Improvement Processes

Quality assurance activities will include the observation of service deliver with individuals, 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.

16.03.10.528 Quality Assurance and Improvement Processes

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.

16.03.10.528 Quality Assurance and Improvement Processes

02. Quality Improvement. Quality improvement consists of the Department working with the provider to resolve identified issues and enhance services provided. Quality improvement activities may include:

a. Consultation and/or;

b. Technical assistance and recommendations, and/or;

c. Corrective Action.

16.03.10.528 Quality Assurance and Improvement Processes

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. Corrective action, as outlined in the Department's Corrective Action Plan Process, includes but is not limited to:

a. Issuance of a corrective action plan, and/or;

b. Referral to Medicaid Program Integrity Unit, and/or;

c. Action against a provider agreement.

Submit Comments Now

Transition Plan

Transition Plan

All families will fully transition into the Enhanced Services based on their current plan end date.

- Plans with start dates between now and June 30, 2019
- Plans expiring in July 2019
- Plans expiring after August 1, 2019

Transition Plan

No intervention can be authorized on a plan of service after July 1, 2019. The following will occur:

- Every child who has a intervention on their existing plan will have a Prior authorization issued for intervention hours to begin effective July 1, 2019. Children will continue to receive the same number of intervention hours as was written on the plan prior to June 30.
- A Notice of Authorization will be mailed to the parent and provider.
- Families must complete the Assessment and Clinical Treatment plan prior to the end of their prior authorization date to continue receiving intervention.
- If additional hours are needed prior to the end of the authorization date, the family can work with their provider to complete an Assessment and Clinical Treatment Plan.

Transition Plan
Start Dates Between Now and June 30

- These plans are currently being written to end intervention on June 30, 2019.
- Prior authorization for intervention for the number of hours on the current plan of service will begin July 1, 2019 and run through the supports plan end date.
- Supports will continue as written on the plan.
- Family will complete Assessment and Clinical Treatment Plan prior to supports plan end date to continue intervention services.

Transition Plan
Plans Expiring July 2019

- These plans are written with no intervention on the plan. Only supports services will be included on these plans.
- Prior authorization for intervention for the number of hours on the previous plan of service will begin July 1, 2019 and run through the supports plan end date.
- Family will complete Assessment and Clinical Treatment Plan prior to supports plan end date to continue intervention services.

Transition Plan
Plans Expiring after August 1, 2019

- These plans have already been written and may have intervention hours written on their plan through the budget.
- Prior authorization for intervention for the number of hours on the plan of service will begin July 1, 2019 and run through the supports plan end date.
- Family will complete Assessment and Clinical Treatment Plan prior to supports plan end date to continue intervention services.
- If there are additional funds remaining in the budget once intervention is removed, families may work with their case manager to write an addendum.

Transition Plan
Act Early

If your child is accessing the Act Early waiver or will access on their new plan before June 30, 2019, please contact your child's case manager and/or your regional supervisor to discuss your child's transition plan.

April Trainings

- The FACS team will be traveling statewide in April to provide Enhancement training to families.
- Schedules available here today. If additional copies are needed, please ask a project staff.