

**IDAPA 16  
TITLE 03  
CHAPTER 10**

**16.03.10 - MEDICAID ENHANCED PLAN BENEFITS**

**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. 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)

**h. 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)

**i. 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)

**j. 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)

**k. 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)

**l. 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)

**m.** 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)

**n.** Respite Care Providers. The criminal history and background check requirements applicable to respite care providers as provided in Sections 329, 526 and 705 of these rules. (7-1-19)T

**o.** 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)

**p.** 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)

**q.** 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)

**COVERED SERVICES**  
**(Sections 075 - 799)**

**075. ENHANCED PLAN BENEFITS: COVERED SERVICES.**

Individuals who are eligible for the Medicaid Enhanced Plan Benefits are eligible for all benefits covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." In addition to those benefits, individuals in the enhanced plan are eligible for the following enhanced benefits as provided for in this chapter of rules. (4-11-15)

**01. Dental Services.** Dental Services are provided as described under Sections 080 through 089 of these rules. (3-29-12)

**02. Enhanced Hospital Benefits.** Organ transplants are provided under the Enhanced Hospital services as described in Sections 090 through 099 of these rules. (3-19-07)

**03. Enhanced Outpatient Behavioral Health Benefits.** Enhanced Outpatient Behavioral Health services are described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (3-20-14)

**04. Enhanced Home Health Benefits.** Private Duty Nursing services are provided under the Enhanced Home Health as described in Sections 200-219 of these rules. (3-19-07)

**05. Therapies.** Physical, Speech, and Occupational Therapy Providers as described in Section 215 of these rules. (3-19-07)

**06. Long Term Care Services.** The following services are provided under the Long Term Care Services. (3-30-07)

**a.** Nursing Facility Services as described in Sections 220 through 299 of these rules. (3-19-07)

**b.** Personal Care Services as described in Sections 300 through 308 of these rules. (3-30-07)

**c.** A & D Wavier Services as described in Sections 320 through 330 of these rules. (3-30-07)

**07. Hospice.** Hospice services as described in Sections 450 through 459 of these rules. (3-19-07)

**08. Developmental Disabilities Services.** (3-19-07)

**a.** Children's Developmental Disability (DD) Home and Community-Based Services (HCBS) State Plan Option as described in Sections 520 through 528 of these rules. (7-1-19)T

**b.** Adult Developmental Disabilities Services as described in Sections 507 through 519, 645 through 657, and 700 through 706 of these rules. (7-1-16)

**c.** ICF/ID as described in Sections 580 through 649 of these rules. (3-19-07)

**09. Service Coordination Services.** Service coordination as described in 720 through 779 of these rules. (3-19-07)

**10. Breast and Cervical Cancer Program.** Breast and Cervical Cancer Program is described in Sections 780 through 800 of these rules. (3-19-07)

**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. Agency.** Developmental disabilities agencies (DDA) are defined in IDAPA 16.03.21, “Developmental Disabilities Agencies (DDA).” (7-1-19)T

**02. 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

**03. Community.** Natural, integrated environments outside of the home, school, or DDA center-based settings. (7-1-19)T

**04. Developmental Disabilities Agency (DDA).** A DDA is an agency that is: (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 individuals 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.** An individual focused planning process directed by the individual or the individual’s decision-making authority and facilitated by the paid or non-paid plan developer. The family-centered planning team discusses the individual’s strengths, needs, and preferences, including the individual’s safety and the safety of those around the individual. This discussion helps the individual the individual’s decision-making authority make informed choices about the services and supports included on the plan of service. (7-1-19)T

**06. Family-Centered Planning Team.** The planning group who helps inform the individual about available services in order to develop the individual’s plan of service. This group includes, at a minimum, the individual, the individual’s decision-making authority, and the plan developer. If the individual is unable to attend the family-centered planning (FCP) meeting, the Plan of Service must contain documentation to justify the individual’s absence. The family-centered planning team must include people chosen by the individual and the family or agreed upon by the individual and the family as important to the process. (7-1-19)T

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

**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. (7-1-19)T

**09. Level of Support.** The amount of services and supports necessary to allow the individual to live

independently and safely in the community.

(7-1-19)T

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

**11. Plan Developer.** A paid or non-paid person who, under the direction of the individual or the individual'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

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

**13. Plan of Service.** An initial or annual plan of service, developed by the individual, the individual'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 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

**14. Practitioner of the Healing Arts, Licensed.** A licensed physician, physician assistant, or nurse practitioner. (7-1-19)T

**15. Prior Authorization (PA).** A process for determining an individual'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

**16. Provider Status Review.** The written documentation that identifies the individual's progress toward goals defined in the plan of service and demonstrates the continued need for the service. (7-1-19)T

**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. (7-1-19)T

**18. Right Place.** Services delivered in the most integrated setting in which they normally occur, based on the individual's choice to promote independence. (7-1-19)T

**19. Right Price.** The most integrated and least expensive services that are sufficiently intensive to address the individual's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (7-1-19)T

**20. Right Outcomes.** Services based on assessed need that ensure the health and safety of the individual and result in progress, maintenance, or delay or prevention of regression for the individual. (7-1-19)T

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

**22. Support Services.** Services that provide supervision and assistance to an individual 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 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. (7-1-19)

**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: (7-1-19)T

a. Documentation of an individual’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 individual 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 individuals whose eligibility is based on developmental disabilities other than intellectual disability. (7-1-19)T

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. (7-1-19)T

c. Medical, Social, and Developmental Summary. (7-1-19)T

**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: (7-1-19)T

a. The individual is birth through seventeen (17) years of age; and (7-1-19)T

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 (7-1-19)T

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. (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 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 (7-1-19)T

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. (7-1-19)T

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

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 (7-1-19)T

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

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

**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 set budget amount. (7-1-19)T

**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. (7-1-19)T

**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. (7-1-19)T

**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 individual. 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. 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 individuals 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 can 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. Adolescent Respite.** Adolescent Respite is a supervision support service provided to individuals ages twelve (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. (7-1-19)T

**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. 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 individual is involved in age-appropriate activities and is engaging with typical peers according to the ability of the individual; 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 shall be adjusted accordingly. (7-1-19)T

**04. Family Education.** Family Education is professional assistance to family members or others who participate in caring for the eligible individual to help them better meet the needs of the individual. It offers education that is specific to the individual needs of the family and individual 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 the individual’s diagnoses. (7-1-19)T

- a. Family Education providers must maintain documentation of the training in the individual’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) individuals’ families. (7-1-19)T

**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.” (7-1-19)T

- 06. 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; or (7-1-19)T
    - ii. Multiple adaptive equipment items address the same goal; or (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 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; and (7-1-19)T
  - ii. Educational services; and (7-1-19)T
  - iii. Recreational services. (7-1-19)T

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

**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. (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 individuals who are significant to the participant. (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 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. (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/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. (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.** (7-1-19)T

**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 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 individual'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 DDA support services must be provided under supervision. The supervisor must meet the qualifications as outlined in IDAPA 16.03.09.575.02-07 "Children's Habilitation Intervention Services." (7-1-19)T

**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. (7-1-19)T

**03. 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. (7-1-19)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 16.05.07.101.01. 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; and (7-1-19)T
- b.** Support services provided during the visit; and (7-1-19)T
- c.** A statement of the participant's response to the service; and (7-1-19)T
- d.** Length of visit, including time in and time out; and (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 following must be completed: (7-1-19)T

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. (7-1-19)T

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. (7-1-19)T

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. (7-1-19)T

ii. Documentation of the six- (6) month and annual reviews must be submitted to the plan monitor. (7-1-19)T

iii. The provider must use Department-approved forms for provider status reviews. (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 DD 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. (7-1-19)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. Must be at least sixteen (16) years of age when employed by a DDA; or (7-1-19)T

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 (7-1-19)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; and (7-1-19)T

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

e. Demonstrate the ability to provide services according to a plan of service; and (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 Services (DDA)." Independent Respite providers must be certified in CPR and first aid prior to delivering services and must maintain current certification thereafter. (7-1-19)T

**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: (7-1-19)T

a. Must be at least eighteen (18) years of age; (7-1-19)T

b. Must be a high school graduate or have a GED; (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 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. (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. 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 one of the following minimum qualifications: (7-1-19)T

- a. Must meet the qualifications of an Intervention Specialist as defined in IDAPA 16.03.09.575.02; or (7-1-19)T
- b. Meet the minimum qualifications of an Intervention Professional as defined in IDAPA 16.03.09.575.03; 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 16.03.09.575.05; 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 16.03.09.575.06. (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

**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. (7-1-19)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 DD HCBS STATE PLAN OPTION: DEPARTMENT’S QUALITY ASSURANCE AND IMPROVEMENT PROCESSES.** Quality assurance activities will include the observation of service delivery 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. (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 may include: (7-1-19)T

**a.** Consultation and/or; (7-1-19)T

**b.** Technical assistance and recommendations, and/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. Corrective action, as outlined in the Department’s Corrective Action Plan Process, includes but is not limited to: (7-1-19)T

**a.** Issuance of a corrective action plan, and/or; (7-1-19)T

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

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

**679. (RESERVED)**

**680-- 699. (RESERVED)**