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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Aged and Disabled Waiver

C. Waiver Number:ID.1076
Original Base Waiver Number: ID.1076.90.R3A.04

D. Amendment Number:ID.1076.R06.05

E. Proposed Effective Date: (mm/dd/yy)

01/01/20

Approved Effective Date: 10/01/19
Approved Effective Date of Waiver being Amended: 10/01/17

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

There are two purposes for this amendment to Idaho's Aged and Disabled (A&D) 1915(c) waiver program.

1) The first purpose is to align the Personal Needs Allowance (PNA) for all participants receiving Home and Community Based Waiver Services (HCBS) who do not have a rent or mortgage expense. Currently, participants without a housing expense who also have a spouse who is not receiving HCBS Waiver services have a higher PNA than the other participants (single or married to a spouse who is receiving HCBS services). CMS determined that the current structure of the PNA categories does not meet reasonableness requirements. This amendment aligns the PNA for all participants who do not have a housing expense to the same PNA value of 100% to comply with CMS requirements.

2) The second purpose of this amendment is in conjunction with the 1915(b) waiver amendment for the Idaho Medicaid Plus program. Idaho Medicaid Plus is a mandatory managed care program for individuals who are eligible for Medicare Parts A and B and full coverage Medicaid, otherwise known as "dual-eligibles." The purpose of Idaho Medicaid Plus is to offer improved coordination of Medicaid-primary services, including behavioral health, Home and Community-Based Services (HCBS), and institutional care.

Idaho has offered a voluntary program for dual-eligibles, including A&D waiver beneficiaries, since 2014 under the Medicare Medicaid Coordinated Plan (MMCP). The MMCP is administered by participating Managed Care Entities (MCEs) under a 1915(a)/(c) combination authority.

Idaho Medicaid Plus is a program that requires dual-eligibles who have not enrolled in the MMCP to enroll with a participating MCE that administers Idaho Medicaid Plus. The 1915(b) waiver permits mandatory enrollment in counties in which there are two or more participating MCEs with a phased-in implementation approach. The program piloted in Twin Falls county in November 1, 2018, and was expanded into additional counties after successful implementation and meeting performance thresholds. Tribal members and individuals who have elected to enroll in the MMCP are excluded from enrollment into Idaho Medicaid Plus.

All existing requirements under the MMCP for the administration of Aged and Disabled waiver services by the MCEs will apply to the Idaho Medicaid Plus program in an identical fashion. The changes to the A&D waiver for these Dual programs include updated language on the IMPlus implementation progress, as well as to to expand the geographic areas served by the MMCP to include the following new counties: Adams, Benewah, Boise, Boundary, Cassia, Elmore, Gem, Gooding, Jefferson, Jerome, Kootenai, Latah, Madison, Minidoka, Owyhee, Payette, Power, Shoshone, Valley, and Washington.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	Main 1.G, 6.I, Attachment #1
☒ **Appendix A Waiver Administration and Operation**	A.6, QI-a.2
☒ **Appendix B Participant Access and Eligibility**	B-5 (b) and (d)
☐ **Appendix C Participant Services**	
☐ **Appendix D Participant Centered Service Planning and**	

Component of the Approved Waiver	Subsection(s)
Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☒ Appendix I Financial Accountability	I-3.g.iii
☒ Appendix J Cost-Neutrality Demonstration	J-2d

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

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

Specify:

Reflect updated service area for managed care delivery system and reflect updated Personal Needs Allowance figures.

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

1. Request Information (1 of 3)

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

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

Aged and Disabled Waiver

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: ID.1076

Waiver Number:ID.1076.R06.05
Draft ID: ID.002.06.07

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/17
Approved Effective Date of Waiver being Amended: 10/01/17

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☒ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☒ **Waiver(s) authorized under §1915(b) of the Act.**

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

Idaho Medicaid Plus - a corresponding 1915(b) waiver amendment will be submitted concurrently with this amendment.

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☒ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The goal of the Aged & Disabled Waiver is to allow Idaho's elderly and disabled citizens who meet nursing facility level of care to choose to live in a home or community-based setting rather than in an institution. This goal is in keeping with the Idaho Department of Health and Welfare's goals of strengthening individuals, families and communities.

Idaho's elderly and disabled citizens should be able to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a safe and cost-effective setting. When possible, services should be available in the participant's own home and/or community regardless of their age, income, or ability, and should encourage the involvement of natural supports, such as family, friends, neighbors, volunteers, church, and others. These principles are built into the structure of Aged & Disabled Waiver, which offers important services in home and community-based settings such as homes and apartments of participants, homes and apartments where participants live with family members, Certified Family Homes, and Residential Assisted Living Facilities.

Individuals seeking services must complete an application for Medicaid with Self-Reliance staff in the Division of Welfare, a division within the Idaho Department of Health and Welfare (referred to hereafter as "the Department"). The Division of Welfare determines financial eligibility for the waiver. The waiver is administered by the Division of Medicaid's Bureau of Long Term Care (BLTC). Requests for waiver services will be sent to one of the appropriate Medicaid offices. A BLTC nurse reviewer will conduct an assessment to assure that nursing facility level of care is met. The nurse reviewer will collaborate with the participant (and/or family or legal representative, as appropriate) in choosing services that ensure the participant can be safely maintained in their choice of living arrangement. The participant (and/or family or legal representative, as appropriate) chooses providers to deliver services. The BLTC is responsible for reassessment annually to make sure the services are being delivered in accordance with the service plan and the services authorized can safely and effectively maintain the participant in their home. The BLTC is also responsible for ensuring that services are delivered by qualified providers with the skills or training necessary to perform the services. The Idaho Department of Health and Welfare's Division of Licensing and Certification ensures that various types of waiver providers are in compliance with applicable statutes and rules governing their license, certificate, and/or credentialed status. Through the development and implementation of a comprehensive quality improvement strategy, the Division of Medicaid assures compliance with the waiver objectives.

For individuals enrolled in the state's Medicare-Medicaid Coordinated Plan (MMCP), the managed care entity (MCE) will administer the waiver in accordance with the same rules by which BLTC administers the waiver for participants not enrolled in the MMCP. The BLTC will supervise the MCE to ensure compliance with the contract with the Department and this waiver. The MCE will perform, to the extent applicable, the same functions as BLTC for its enrollees who are waiver participants. The BLTC will continue to complete the level of care assessments for all A&D waiver participants, regardless of whether they are enrolled in the MMCP. Any references to duties of the MCE apply only to individuals who are enrolled in the state's MMCP.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

I. Public Input. Describe how the state secures public input into the development of the waiver:

The Department continues to engage in extensive outreach efforts to inform stakeholders of this waiver program. The Department has provided opportunities to provide public comment on associated deliverables related to continued MMCP/Idaho Medicaid Plus implementation and the alignment of the PNA for all participants who do not have a shelter expense (regardless of marital status). Outreach activities include:

1. Recurring meetings with the Personal Assistance Oversight Committee (PAO). The PAO is a subcommittee of the Medical Care Advisory Committee (MCAC). The purpose of the PAO is to plan, monitor, and recommend changes to the Medicaid HCBS waivers and personal assistance programs. Such recommendations would be submitted to the MCAC. The PAO consists of providers of personal assistance services and participants of such services, advocacy organizations representing such participants, and other interested parties. This committee meets quarterly and is open to the public. The changes proposed in this draft waiver amendment will be discussed during the October 4, 2019 PAO meeting.

2. Tribal solicitations were mailed to the Tribal Representatives of the six federally recognized tribes in Idaho on August 28, 2019 and solicited verbal and written comments regarding the proposed waiver amendment over the 31-day period beginning August 28, 2019 through close of business September 27, 2019. Tribal comments were solicited to be received via telephone and email. In addition, ongoing feedback was solicited from Tribal representatives during the quarterly Tribal Meetings. The proposed program changes to MMCP and PNA alignment were discussed during the August 14, 2019 meeting. This tribal notification was also posted on August 28, 2019 to the Idaho Medicaid Program & Tribes of Idaho Teamsite located at https://healthandwelfare.idaho.gov/meditribe/Home/tabid/1331/Default.aspx.

3. Changes to Idaho Administrative Code (IDAPA) to align the PNA for all participants who do not have a housing expense (regardless of marital status) require outreach as part of the rule promulgation process. A Negotiated Rulemaking meeting was hosted on June 18, 2019 in Boise, Idaho, with a WebEx and toll-free conference call option for those unable to attend in person to share information about the proposed rules and solicit feedback. Attendees did not have formal comments pertaining to the proposed rules during the meeting. The Department received three written comments after the meeting. A Comment Summary and Response Document is available on the Medicaid website (https://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/Rulemaking/160318MedicaidCostSharingNegotiatedRulema
Public hearings to solicit additional testimony about the alignment of the PNA are scheduled in Boise on October 11, 2019. An accompanying WebEx and toll-free call option is scheduled for statewide participation or as an option for those unable to attend the hearing in person.

5. The Department has regular recurring meetings with the Health Plans administering the MMCP, and the new geographic service area is a topic of ongoing discussions.

6. The Department published notices in the newspapers of widest circulation in the state, the Idaho Press Tribune, the Idaho Statesman, the Idaho State Journal, the Post Register, and the Coeur D'Alene Press, soliciting comments regarding the proposed Aged and Disabled 1915(c) waiver amendment via mail, email, fax, and telephone from August 30, 2019 through close of business on September 30, 2019.

The Department made the draft A&D waiver amendment available for public review on August 30, 2019, in all regional Department of Health and Welfare offices. These materials were also posted on the main Medicaid webpage at https://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx under "Proposed Changes and Public Notice for Waiver Services."

The Department did not receive any comments from tribal representatives or the public regarding this draft waiver amendment.

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

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

Proficient persons.

7. Contact Person(s)

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

Last Name: Pinkerton

First Name: Jennifer

Title: Medicaid Program Policy Analyst

Agency: Department of Health and Welfare - Division of Medicaid

Address: P.O. Box 83720

Address 2:

City: Boise

State: **Idaho**

Zip: 83720-0009

Phone: (208) 287-1171 **Ext:** ☐ **TTY**

Fax: (208) 332-7283

E-mail: Jennifer.Pinkerton@dhw.idaho.gov

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

Last Name: Wimmer

First Name: Matt

Title: Medicaid Administrator

Agency: Department of Health and Welfare - Division of Medicaid

Address: P.O. Box 83720

Address 2:

City: Boise

State: **Idaho**

Zip: 83720-0009

Phone: (208) 364-1831 **Ext:** ☐ **TTY**

Fax: (208) 364-1811

E-mail: Matt.Wimmer@dhw.idaho.gov

8. Authorizing Signature

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

Signature: Robin Butrick

State Medicaid Director or Designee

Submission Date: Dec 12, 2019

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

Last Name: Robin

First Name: Butrick

Title: Policy Analyst

Agency: Idaho Department of Health and Welfare, Division of Medicaid

Address: 3232 Elder St.

Address 2:

City: Boise

State: **Idaho**

Zip: 83705

Phone:

(208) 364-1836 **Ext:** ☐ **TTY**

Fax:

(208) 364-1811

E-mail:

Robin.Butrick@dhw.idaho.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☒ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Participants who are full dual-eligibles and are receiving services under the Aged and Disabled waiver, and reside in a county in which the Department secures approval under a concurrent 1915(b) waiver amendment to operate a mandatory managed care program, have their benefits administered by a participating MCE under the Idaho Medicaid Plus program.

All Participants with existing Aged and Disabled waiver services and service providers can retain their existing provider, even if the provider is out of the MCE network, for up to 120 days after transitioning to Idaho Medicaid Plus. The MCE is required to conduct outreach to the provider to attempt to establish a contract or help facilitate a transition to an in-network provider as needed. If a Participant's preferred provider has not established a contract with the MCE after the 120-day transition period has passed, the MCE's Care Specialist will work with the Participant to select an in-network provider. Historically, the MCEs have continued to pay for an out of network provider as long as the provider has already entered into the contracting process.

All participants maintain the same level of service under Idaho Medicaid Plus as under fee-for-service Medicaid.

The Department has developed a new contract with the existing MCEs that currently operate the MMCP to administer the Idaho Medicaid Plus program to expand ID Medicaid Plus coverage to additional counties in Idaho. Medicaid seeks to phase-in implementation of mandatory enrollment in these additional counties. The Department successfully implemented Idaho Medicaid Plus as a pilot program in Twin Falls County in November, 2018. After the Department verified that performance benchmarks were met (including continuity of care indicators, claims payment requirements, and outreach activities), Idaho Medicaid Plus expanded to Bannock, Bingham, and Bonneville counties in April 2019, followed by Bonner, Kootenai, and Nez Perce in June 2019. The most recent expansion of Idaho Medicaid Plus occurred in Ada and Canyon Counties in August 2019. Expansion of mandatory enrollment beyond the currently active counties will be contingent upon the Health Plans meeting required performance benchmarks as specified in the contract.

The Department plans to expand the Idaho Medicaid Plus program to the following additional twelve (12) counties effective April 1, 2020: Boise, Boundary, Cassia, Elmore, Fremont, Gem, Jefferson, Madison, Minidoka, Owyhee, Payette, and Power. The Department will send letters to all Participants in these counties who have not opted to enroll in the MMCP. Participants will have 90 days to select a health plan or voluntarily enroll in the MMCP. Participants who do not actively select a health plan for Idaho Medicaid Plus will be auto-assigned using an algorithm in the MMIS, resulting in a 50/50 split between both health plans. Idaho Medicaid Plus effective date for Participants in each of these counties begins April 1, 2020, and Participants will have 90 days to change their health plan. After that 90 days, Participants will only be able to change health plans during Open Enrollment.

The Department plans to expand the MMCP to the following additional nine (9) counties effective January 1, 2020: Adams, Benewah, Clark, Gooding, Jerome, Latah, Shoshone, Valley, and Washington. The health plans will complete marketing and outreach to the Participants in these counties. Participants in these counties can enroll in the MMCP any time after January 1, 2020; the effective date will be the prospective for the first day of the month following enrollment.

The Department continues to notify enrollees of the pending implementation of Idaho Medicaid Plus. Participants will not have an opportunity to request a fair hearing pertaining to enrollment into Idaho Medicaid Plus if they are in a mandatory county under the 1915(b) waiver. Participants will retain the same services and level of service after transitioning to the (b) waiver. Participants are advised of their MCE and State Fair Hearing rights with any adverse benefit determination on the notice of decision letters sent by both the state (for termed services when they enroll in a Duals program) and the Health Plan (for approved services upon enrollment in a Duals program), including instances in which individuals are denied the provider of their choice due to the provider not being in the MCE's network. Participants are referred to the Fair Hearing process as outlined in Appendix F-1.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the State's most recent and/or approved Home and Community-Based Settings Statewide Transition Plan. The State will implement any required changes by the end of the transition period as outlined in the Home and Community-Based Settings Statewide Transition Plan

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

◉ **The Medical Assistance Unit.**

Specify the unit name:

Division of Medicaid, Bureau of Long Term Care

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The MCE shall authorize A&D Waiver services to meet participants' needs for assistance in accordance with the results of the Uniform Assessment Instrument (UAI). The service authorization process shall be integrated with the MCE's authorization process for covered physical health and behavioral health services.

The MCE must develop, update, and monitor an Individualized Care Plan for each participant utilizing the complete UAI results with the participant and any appropriate Interdisciplinary Care Team (ICT) members. The MCE shall provide information, choice and supports that include the availability of an individual to educate and assist the participant in self- direction. The MCE must pay for services rendered by a Fiscal Intermediary Agency functioning as an employer of record for participants who direct their own services. The MCE must also provide the participant with the option of having their A&D Waiver services provided by a Personal Assistance Agency.

The MCE will also collect and track data regarding utilization patterns, consumer direction of HCBS, and quality management/quality improvement to submit regular reports to the Department.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Idaho Division of Medicaid is responsible for assessing the performance of the contracted MCEs under the MMCP and Idaho Medicaid Plus contract(s).

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The following are the methods used to monitor the MMCP and Idaho Medicaid Plus:

The IDHW engages in ongoing contract monitoring, and this includes performance monitoring of the MCE. This performance monitoring includes review of documentation as well as onsite monitoring at operational facilities and business offices that handle any component of the Contract requirements.

During any form of performance monitoring, the MCE or any network provider or subcontractor will provide to IDHW any client treatment records, logbooks, staffing charts, time reports, claims data, administrative documents, complaints, grievances, and any other documents and data as requested when, at the discretion of the IDHW, it is determined to be required to assess the performance of the MCE, a network provider or subcontractor.

If monitoring activities are conducted at a provider location, they will be conducted in a manner so as not to disrupt the provision of treatment to clients.

Any monitoring performed may or may not be scheduled in advance and may last for several days.

The performance level of the MCE or a network provider or subcontractor may affect the frequency of the monitoring.

The IDHW reserves the right to monitor any aspect of the contract.

Additionally, if IDHW receives continued unresolved client or provider network complaints regarding service issues, the IDHW will initiate a focused monitoring of that area, utilizing at least one of the performance criteria listed in the Contract. IDHW will then follow the reporting, cure period, and appeal process as outlined in the Contract. The current Contract may be viewed under the "Important Information" tab at the following webpage:

http://healthandwelfare.idaho.gov/Medical/Medicaid/MedicaidParticipants/MedicareMedicaidCoordinatedPlan/tabid/2538/Default.a

Areas in which performance deficiencies have been found may be followed continually, or subsequently re-examined as designated by the IDHW.

General requirements applicable to all clients will typically be assessed via a randomly selected data review of approximately ten percent (10%) sample of client files at a provider location or at the health plan's primary facility. Other requirements, relevant to a segment of the client population, may be reviewed using a higher percentage, up to one hundred percent (100%) of the records of a sub-population. Areas in which performance deficiencies have been found may be re-examined in the subsequent quarter or follow up period, as designated by the IDHW, in order to gauge progress towards satisfactory performance.

The IDHW will monitor the contract(s) for the MMCP program by reviewing reports in the following areas on a weekly, monthly, semi-annual, annual, or as-needed basis, depending on the frequency requirement for the report:

1. Provider Network: Quarterly
2. Provider Payment: Quarterly
3. Utilization Management: Quarterly
4. Quality Management/Quality Improvement: Quarterly
5. Customer Service/Provider Service: Quarterly
6. Fraud and Abuse: Quarterly
7. Financial Management: Quarterly
8. Claims Management: Quarterly
9. Information Systems: Quarterly and annually
10. Administrative Requirements: Semi-annually
11. HIPAA: Quarterly
12. Non-Discrimination Compliance: Quarterly
13. Specialized Service: Quarterly
14. Other: as indicated

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of remediation issues identified by contract monitoring reports that were addressed by the state. a. Numerator: Number of identified remediation issues addressed by the state. b. Denominator: Number of remediation issues identified by contract monitoring reports.

Data Source (Select one):
Program logs
If 'Other' is selected, specify:
Contract Monitoring Issue Log

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

Data Aggregation and Analysis:

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

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

The IDHW uses a SharePoint site to document, track, resolve, and subsequently analyze issues in the administration and operation of the MMCP and Idaho Medicaid Plus by the MCE. The BLTC and MCE have internal policies and procedures regarding use of this Issue Log. Issues may be identified during routine daily contract monitoring activities, such as reviewing data reports, on-site audits, desk reviews, reviewing grievance/appeal data, etc. In addition, issues may be identified during the day-to-day work of IDHW or MCE staff that perform functions associated with the MMCP or Idaho Medicaid Plus. Once an issue is logged, the Contract Monitor assigns the issue to the appropriate party for investigation and resolution and identifies a due date. The Contract Monitor reviews the follow-up information entered for the Issue and determines if the issue has been resolved satisfactorily, or if additional work is required. In the event of unresolved issues, these may be escalated as performance deficiencies.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The following are the State's methods for addressing individual problems as they are discovered:

The IDHW Contract Monitor reviews every Issue that is entered into the Issue Log and responds within one (1) business day. The Contract Monitor assigns the issue to the appropriate person for investigation and resolution – that individual or group may be MCE personnel, or IDHW personnel, depending on the nature of the issue. When applicable, the Contract Monitor cites the specific Scope of Work provisions being impacted by the issue and assigns a priority level for resolution. The Contract Monitor routinely monitors the issue log throughout the course of each business day to identify and analyze any trends or recurring problems, as these may rise to the level of performance deficiencies.

The Contract Monitor will issue a Monitoring Report to the MCE on a monthly basis that identifies in writing the Performance Indicator(s) monitored, and that summarizes the preliminary results with the MCE. The MCE utilizes the same sampling methods as the IDHW for performance and quality improvement measures. Upon request by the MCE, the IDHW will meet with the MCE within ten (10) business days of their receipt of the Monitoring Report regarding the results. The MCE may dispute the findings via written appeal to the Contract Monitor within ten (10) business days of issuance of the report. The MCE must specifically address each disputed finding and justification for the appeal of the finding. The MCE is required to provide all documents necessary to dispute monitor results with its written appeal. The IDHW will render a final written decision on the appeal to the MCE within ten (10) business days of receipt of the MCE's dispute information, unless the parties agree in writing to extend the decision period.

If the MCE does not dispute the findings, the MCE shall have ten (10) business days from the date of the IDHW's monitoring report to cure the deficiencies found. If the MCE appeals the monitoring report, the MCE shall have ten (10) business days from the date of the IDHW's final written decision to cure the deficiencies. If the IDHW is not satisfied that the MCE has resolved the deficiencies, or made substantial progress toward resolution, the IDHW may assess an invoice reduction(s) in the amounts listed in the Scope of Work as liquidated damages for each day the deficiency remains uncured. The type of issue and corresponding invoice reduction amount varies by the severity of the issue; this information is captured in the MCE Contract with the Department. For instances where an identified issue must be remediated, but no Contract provision or invoice reduction currently exists, the state may impose a new invoice reduction to ensure remediation is achieved.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design

methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	18	64	
	☒	**Disabled (Other)**	18	64	
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

To qualify for the disabled (physical) or disabled (other) target group, an individual must meet the definition of blindness or disability used by the Social Security Administration for Retirement, Survivors, and Disability Insurance and Supplemental Security Income benefits.

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

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

In accordance with IDAPA 16.03.05.788, in order to be eligible for the Aged and Disabled (A&D) Waiver, the participant must:

01. Age Eighteen Through Sixty-Four. Be eighteen (18) through sixty-four (64) years old and meet both the disability criteria, as provided in Section 156 of these rules, and need nursing facility level of care as provided in IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits"; or

02. Age Sixty-Five or Older. Be age sixty-five (65) or older and need nursing facility level of care as provided in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits."

Therefore, an individual may remain on the A&D waiver so long as that individual is at least eighteen (18) years old and meets all other applicable requirements.

Appendix B: Participant Access and Eligibility

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

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

○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

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

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

The following is the procedure that is followed to determine in advance of waiver entrance that the applicant/participant's health and welfare can be assured within the cost limit. For a participant who is enrolled with an MCE, the MCE will complete these functions to the extent applicable (i.e., initial appeals for MCE enrollees are routed to the MCE rather than through the state fair hearing process).

1. In advance of waiver entrance, nurse reviewers utilize the assessment and established processes to ensure that the individual's health and welfare can be assured within the cost limit. Nurse reviewers interview the participant (and/or family or legal representative, as appropriate. Questions from the Uniform Assessment Instrument (UAI) are used to determine the services needed and those not provided by family or community sources. Nurse reviewers use their professional judgment to determine whether the individual meets nursing facility level of care requirements and whether the individual can be safely maintained in the living situation of their choice with these services. The nurse reviewer uses the initial service plan meeting to help make this determination. This meeting involves the nurse reviewer, the participant, guardian, family members, and other pertinent individuals. After the determination is made, the cost of waiver services is compared to the cost limit.

2. If the cost of services is above the cost limit, a special rate may be considered. A special rate consists of an amount in addition to the nursing facility daily rate when a participant has needs that are beyond the scope of facility services, and when the cost of providing for those additional needs is not adequately reflected in the rates calculated pursuant to the principles found in Idaho Code. This special rate add-on amount for such specialized care is in addition to any payments made in accordance with other payment provisions. The Department (or the MCE for MCE enrollees) determines to approve a special rate on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request must be based on an identified condition that will continue for a period greater than thirty (30) days. The nurse reviewer will request a special rate from Medicaid central office following the process outlined in the Bureau of Long Term Care manual. The cost of services or equipment and diagnosis or medical condition information is submitted. The central office compares this information to a similar diagnosis or medical condition for a nursing facility (NF) individual. When a NF providing services for an individual with a similar diagnosis or medical condition is reimbursed at a higher special rate, that rate may be paid for an individual on the waiver even if it exceeds the cost limit.

3. A reassessment will be done annually to determine the special rate is still warranted and that the services still maintain the participant in a safe and effective manner.

4. Participants (and/or family or legal representative, as appropriate) may appeal a Department decision following the same method as any decision using the appeal process found in Idaho Administrative Code 16.05.03.100-104 "Rules Governing Contested Case Proceedings and Declaratory Rulings". An applicant/participant (and/or family or legal representative, as appropriate) has a right to request a hearing when he disagrees with a Department action which delayed making an eligibility decision, making a payment, or a payment adjustment beyond specified time limits, reduces payment amount to participant, terminates aid or services to a participant, or terminates provider status. The applicant/participant (and/or family or legal representative, as appropriate) may request a hearing if they dispute amount, manner, or form of aid, including prospective payments or dispute the Department's decision to deny services or benefits.

5. When a decision is appealable, the Department will advise the applicant/participant (and/or family or legal representative, as appropriate) in writing of the right and method to appeal and the right to be represented. The Department will mail the applicant/participant (and/or family or legal representative, as appropriate) a Notice of Decision containing the appeal rights and the request for hearing information. The appeal rights and the request information are available to applicant/participant (and/or family or legal representative, as appropriate) on the Notice of Decision.

6. Appeals must be filed in writing and state the appellant's name, address, and phone number, and the remedy requested. Appeals should be accompanied by a copy of the Notice of Decision that is the subject of the appeal. Appellants have twenty-eight (28) days from the date the decision is mailed to file an appeal. The appellant may send the request for a hearing to the Hearing Coordinator Department of Health & Welfare Administrative Procedures Section or to the Medicaid office. Medicaid staff will forward the request to the Hearing Coordinator. An appeal is filed when it is received by the Department or postmarked within the time limits. The appellant may request a Fair Hearing Request Form from the Department if they wish to continue receiving benefits until a decision has been made by the hearing officer.

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the

participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☒ **Additional services in excess of the individual cost limit may be authorized.**

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

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

1. Post-entrance to the waiver, nurse reviewers utilize the assessment and established processes to ensure that the individual's health and welfare can be assured within the cost limit. Nurse reviewers interview the participant and pertinent caregiver and family members using the questions on the Uniform Assessment Instrument (UAI) to determine the services needed and those not provided by family or community sources. Nurse reviewer uses professional judgment to determine whether the individual can be safely maintained in the living situation of their choice with these services. After the determination is made, the cost of waiver services is compared to the cost limit.

2. If there is a change in the participant's condition or circumstances that requires the provision of services in an amount that exceeds the cost limit, a special rate may be considered as a safeguard to avoid adverse impact on the participant. A special rate consists of an amount in addition to the nursing facility daily rate when a participant has needs that are beyond the scope of facility services and when the cost of providing for those additional needs is not adequately reflected in the rates calculated pursuant to the principles found in Idaho Code. This special rate add-on amount for such specialized care is in addition to any payments made in accordance with other payment provisions. The Department (or the MCE in the case of MCE enrollees) determines to approve a special rate on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request must be based on an identified condition that will continue for a period greater than thirty (30) days. The nurse reviewer will request a special rate from Medicaid central office following the process outlined in the Bureau of Long Term Care manual. The cost of services or equipment and diagnosis or medical condition information is submitted. The central office compares this information to a similar diagnosis or medical condition for a nursing facility individual. When a NF providing services for an individual with a similar diagnosis or medical condition is reimbursed at a higher special rate, that rate may be paid for an individual on the waiver even if it exceeds the cost limit.

3. A reassessment will be done annually to determine the special rate is still warranted and that the services still maintain the participant in a safe and effective manner.

4. If the participant's condition changes, the participant (and/or family or legal representative, as appropriate) may contact the nurse reviewer or MCE registered nurse to request an increase in services or the agency may complete a Significant Change/Modification Request form. After the nurse reviewer receives the request for additional services, the participant and or family and agency will be contacted by the nurse reviewer. The nurse reviewer or MCE registered nurse may schedule a meeting with other Department or MCE staff, as applicable, and the participant, guardian, family members and other pertinent individuals to discuss the change. The nurse reviewer or MCE registered nurse will update the current UAI to reflect the participant's needs. The nurse reviewer or MCE registered nurse will ensure that the revised plan is safe and effective, participant continues to meet level of care and the plan is cost effective. A revised UAI and a revised Negotiated Service Plan are sent to the agency.

5. Participants (and/or family or legal representative, as appropriate) may appeal a Department decision following the same method as any decision using the appeal process found in Idaho Administrative Code 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." The Department will ensure that initial appeals for participants enrolled in the MMCP that relate to the MCE’s actions will be resolved by the MCE, but participants retain access to the state’s fair hearing system if the MCE does not wholly resolve the appeal in favor of the participant.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	11485
Year 2	11944
Year 3	12422
Year 4	12919
Year 5	13436

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

- (●) **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals

experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

Individuals ages 65 and older may be eligible for entrance to the waiver. Individuals ages 18 - 64 may also be eligible for entrance to the waiver if they meet disability requirements. All waiver participants must meet nursing facility level of care as assessed by the Uniform Assessment Instrument. All waiver participants must also have income less than or equal to 300% of the SSI Federal Benefit Rate.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

- ( ) **§1634 State**
- (●) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ○ **No**
- ◉ **Yes**

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

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

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

  Select one:

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

  Specify percentage:

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

  Specify:

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

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

  Select one and complete Appendix B-5.

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

CFR §435.217

Check each that applies:

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

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

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

Specify dollar amount: [ ]

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

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

Specify percentage amount: [ ]

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b

State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

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

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

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

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

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

○ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

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

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

Specify:

The base Personal Needs Allowance (PNA) equals 100% of the SSI FBR. The maximum PNA is equal to 180% of the SSI FBR. Additional variances from the base PNA are as follows:

If a person:
1) Does not reside in Adult Residential Care or a Certified Family Home (CFH) and
2) Has a rent/mortgage obligation,
Then the variance to the base PNA is any countable income up to 180% of SSI FBR.

If a person:
1) Has no rent or mortgage obligation, or
2) Resides in Adult Residential Care or a CFH,
Then the following variances are applied, subject to the maximum PNA of 180% of the SSI FBR:

Persons with earned income. The PNA is increased by $200 or the amount of their earned income, whichever is less. A greater variance is needed to offset costs incurred in earning income (and which are distinct from impairment-related work expenses described below).

Persons with taxes mandatorily withheld from unearned income for income tax purposes before the individual receives the income. A greater variance is needed to offset mandatory income taxes.

Persons with court-ordered guardian. The PNA is increased by guardianship fees not to exceed 10% of the monthly benefit handled by the guardian, or $25, whichever is less. Where the guardian and the trustee are the same individual, the total deduction for guardian and trust fees must not exceed $25. A greater variance is needed to offset guardian fees.

Persons with a trust. The PNA is increased by trust fees, not to exceed $25 paid to the trustee for administering the trust. A greater variance is needed to offset trust fees.

Blind or disabled employed persons with impairment-related work expenses. Impairment-related work expenses are items and services purchased or rented to perform work. The items must be needed due to the participant's impairment. The actual monthly expense of the impairment related items is deducted. Expenses must not be averaged. A greater variance is needed to offset impairment-related work expenses.

See IDAPA 16.03.18.400, IDAPA 16.03.05.723, and IDAPA 16.03.05.725

The Department ensures that patient liability, or Share of Cost (SOC), is applied only to the cost of home and community-based waiver services in both the fee-for-service (FFS) environment and the Medicare Medicaid Coordinated Plan (MMCP) under a capitated system. The Division of Self Reliance (the State entity that determines participant financial eligibility) applies the post-eligibility treatment of income calculation to determine participant SOC. For FFS participants, this SOC amount is then applied in the MMIS as a deduction to the first claim submitted by a participant's HCBS service provider each month. The provider is responsible for collecting the SOC amount from the participant. For participants enrolled in the MMCP, the SOC figure is relayed to the MCE as part of the eligibility file transmission. The MCE then applies SOC in the same fashion: by deducting the amount from the first claim submitted by the participant's HCBS service provider each month.

The long-term services and supports (LTSS) component of the blended capitation payment that is made to the MCE by the Department is derived from actual claims paid amounts (rather than claims billed) from the MMIS – which accounts for participant SOC by not including it in the capitation rate since the participant pays this amount. When the Department conducts its annual Medical Loss Ratio (MLR) review and settlement process with the MCE, actual MCE claims expenses are reviewed. Each component of the blended rate is adjusted as necessary – including the LTSS component, which accounts for participant SOC in the capitated system as we have described. Therefore, patient liability is only applied to the cost of HCBS services and not other Medicaid state plan services.

○ **Other**

Specify:

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

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

Specify:

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

- ( ) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

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

- ( ) **The amount is determined using the following formula:**

Specify:

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

- ( ) **Not Applicable (see instructions)**
- (●) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

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

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

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

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

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

Specify percentage:

○ **The following dollar amount:**

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

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

Specify formula:

The base Personal Needs Allowance (PNA) equals 100% of the SSI FBR. The maximum PNA is equal to 180% of the SSI FBR. Additional variances from the base PNA are as follows:

If a person:
1) Does not reside in Adult Residential Care or a Certified Family Home (CFH), and
2) Has a rent/mortgage obligation,
Then the variance to the base PNA is any countable income up to 180% of SSI FBR.

If a person:
1) Has no rent or mortgage obligation, or
2) Resides in Adult Residential Care or a CFH,
Then the following variances are applied, subject to the maximum PNA of 180% of the SSI FBR:

Persons with earned income. The PNA is increased by $200 or the amount of their earned income, whichever is less. A greater variance is needed to offset costs incurred in earning income (and which are distinct from the impairment-related work expenses described below).

Persons with taxes mandatorily withheld from unearned income for income tax purposes before the individual receives the income. A greater variance is needed to offset mandatory income taxes.

Persons with court-ordered guardian. The PNA is increased by guardianship fees not to exceed 10% of the monthly benefit handled by the guardian, or $25, whichever is less. Where the guardian and the trustee are the same individual, the total deduction for guardian and trust fees must not exceed $25. A greater variance is needed to offset guardian fees.

Persons with a trust. The PNA is increased by trust fees, not to exceed $25 paid to the trustee for administering the trust. A greater variance is needed to offset trust fees.

Blind or disabled employed persons with impairment-related work expenses. Impairment-related work expenses are items and services purchased or rented to perform work. The items must be needed due to the participant's impairment. The actual monthly expense of the impairment-related items is deducted. Expenses must not be averaged. A greater variance is needed to offset impairment-related work expenses.

See IDAPA 16.03.18.400, IDAPA 16.03.05.723, and IDAPA 16.03.05.725

○ **Other**

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

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

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

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

Licensed Professional Nurse (Registered Nurse, RN) licensed in the State of Idaho perform the initial evaluation of level of care for waiver applicants.

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

(if applicable), including the instrument/tool utilized.

Nursing Facility Level of Care is the criteria used to evaluate and reevaluate whether an individual needs services through the waiver. Idaho has developed a Uniform Assessment Instrument (UAI) as the basis of the level of care instrument. The purpose of the Uniform Assessment Instrument (UAI) is to gather information for determining participant's care needs, service eligibility and for planning participant services. The UAI is a multidimensional questionnaire which assesses a participant's functioning level, social skills, and physical and cognitive abilities. It provides a comprehensive assessment of a participant's actual functioning level including those elements that are necessary for developing an individualized service plan. The UAI was designed to provide a standardized way of conducting a participant interview to ensure that all participants have an objective assessment of their needs.

The UAI measures deficits in ADLs, IADLs, Behavioral and Cognitive Functioning. A score of 12 points is needed to demonstrate NF LOC. Idaho Administrative Procedure defines this in IDAPA 16.03.10.322.04-.08, "Medicaid Enhanced Plan Benefits."

Functional Level for Adults. Based on the results of the UAI , the level of impairment of the individual will be established by the Department. In determining need for nursing facility care an adult must require the level of assistance according to the following formula:
Critical Indicator - 12 Points Each.
a. Total assistance with preparing or eating meals.
b. Total or extensive assistance in toileting.
c. Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking.

High Indicator - 6 Points Each.
a. Extensive assistance with preparing or eating meals.
b. Total or extensive assistance with routine medications.
c. Total, extensive or moderate assistance with transferring.
d. Total or extensive assistance with mobility.
e. Total or extensive assistance with personal hygiene.
f. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI).

Medium Indicator - 3 Points Each.
a. Moderate assistance with personal hygiene.
b. Moderate assistance with preparing or eating meals.
c. Moderate assistance with mobility.
d. Moderate assistance with medications.
e. Moderate assistance with toileting.
f. Total, extensive, or moderate assistance with dressing.
g. Total, extensive or moderate assistance with bathing.
h. Extensive or moderate assistance with supervision from Section II No. 18 of the UAI.

Nursing Facility Level of Care, Adults. In order to qualify for nursing facility level of care, the individual must score twelve (12) or more points in one (1) of the following ways.
a. One (1) or more critical indicators = Twelve (12) points.
b. Two (2) or more high indicators = Twelve (12) points.
c. One (1) high and two (2) medium indicators = Twelve (12) points.
d. Four (4) or more medium indicators = Twelve (12) points.

The Bureau of Long Term Care (BLTC) Manual and the Uniform Assessment Instrument Resource Manual aid the nurse reviewer in completing the UAI.

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

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

state plan.

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

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

The Uniform Assessment Instrument (UAI) is utilized gather information for determining a participant's care needs, service eligibility and for planning participant services. The UAI is a multidimensional questionnaire which assesses a participant's functioning level, social skills, and physical and cognitive abilities. It provides a comprehensive assessment of a participant's actual functioning level including those elements that are necessary for developing an individualized service plan. The UAI was designed to provide a standardized way of conducting a participant interview to ensure that all participants have an objective assessment of their needs.

The nurse reviewer conducts a face to face interview of the participant (and/or family or legal representative, as appropriate) in their home/community based setting using the questions on the Uniform Assessment Instrument. Additional information may be provided by caregivers, family or legal representative as appropriate. The tool is computerized and calculates the score based on the unmet needs/available supports to determine the level of assistance required of the participant.

A score of 12 points is needed to demonstrate NF LOC. Idaho Administrative Procedure defines this in IDAPA 16.03.10.322.04-.08 "Medicaid Enhanced Plan Benefits."

Functional Level for Adults. Based on the results of the UAI, the level of impairment of the individual will be established by the Department. In determining need for nursing facility care an adult must require the level of assistance according to the following formula:
Critical Indicator - 12 Points Each.
a. Total assistance with preparing or eating meals.
b. Total or extensive assistance in toileting.
c. Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking.

High Indicator - 6 Points Each.
a. Extensive assistance with preparing or eating meals.
b. Total or extensive assistance with routine medications.
c. Total, extensive or moderate assistance with transferring.
d. Total or extensive assistance with mobility.
e. Total or extensive assistance with personal hygiene.
f. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI).

Medium Indicator - 3 Points Each.
a. Moderate assistance with personal hygiene.
b. Moderate assistance with preparing or eating meals.
c. Moderate assistance with mobility.
d. Moderate assistance with medications.
e. Moderate assistance with toileting.
f. Total, extensive, or moderate assistance with dressing.
g. Total, extensive or moderate assistance with bathing.
h. Extensive or moderate assistance with supervision from Section II No. 18 of the UAI.

Nursing Facility Level of Care, Adults. In order to qualify for nursing facility level of care, the individual must score twelve (12) or more points in one (1) of the following ways.
a. One (1) or more critical indicators = Twelve (12) points.
b. Two (2) or more high indicators = Twelve (12) points.
c. One (1) high and two (2) medium indicators = Twelve (12) points.
d. Four (4) or more medium indicators = Twelve (12) points.

The Bureau of Long Term Care (BLTC) Manual and the Uniform Assessment Instrument Resource Manual and professional judgment aid the nurse reviewer in completing the UAI.

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

- ○ **Every three months**
- ○ **Every six months**

- (●) **Every twelve months**
- ( ) **Other schedule**
  Specify the other schedule:

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

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

To ensure timely level of care reevaluations, Medicaid staff run reports via a computerized database. The database is available on the Department's Internet maintained by the Information Technology Division. Program managers run monthly reports to monitor timeliness of reevaluations.

To ensure timely level of care reevaluations for participants enrolled in the MMCP or Idaho Medicaid Plus, the MCE registered nurse submits an electronic workflow request to the Medicaid nurse reviewer 45 days prior to the due date. These requests are routed to the appropriate Medicaid nurse reviewer for completion and are then returned to the MCE. The Contract Monitor uses this system to generate reports and to monitor timeliness of reevaluations for MMCP and Idaho Medicaid Plus enrollees.

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

Written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum of three (3) years. Electronic records are maintained on a database in a web format. Paper records are maintained for five (5) years.

The MCE retains written and/or electronically retrievable documentation of all evaluations and reevaluations under the contract for a period of six (6) years in accordance with 42 CFR § 455, 45 CFR § 164.530(j)(2) and IDAPA 16.03.09.205, or for the duration of contested case proceedings, whichever is longer.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of applicants for HCB services who received a Level of Care assessment prior to receiving services. a. Numerator: Number of applicants for HCB services who received a Level of Care assessment prior to receiving services. b. Denominator: Number of applicants for HCB services.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied***

appropriately and according to the approved description to determine participant level of care.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of Level of Care determinations made according to criteria. a. Numerator: Number of Level of Care determinations made according to criteria within the representative sample. b. Denominator: Number of Level of Care determinations in the representative sample.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: 420 (5 per Region, per month)
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

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

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

Uniform Assessment Instrument (UAI) Report:
Information on the numbers of assessments (initial & redetermination) and significant changes are retrieved from the Assessment and Certification Tool (ACT) database and the MMIS. Medicaid Central Office compiles the information into a report that goes to the Bureau of Long Term Care Committee (BLTCC) or designee for analysis on workload and case load distribution.

Internal File Audit:
Each Regional Nurse Manager (NM) conducts a minimum of five A&D internal file audits each month. The accuracy of the NR's Level of Care (LOC) decision is reviewed, including whether the narrative and documentation support the level designated for each category of care needs. The NM enters the results of the Internal File Audit into the BLTC Quality Improvement Tracking Tool. Medicaid Central Office compiles statewide reports on statewide trends to BLTCC or designee.

QI Processes and Instruments:
Quality Improvement Team (QIT) reviews the QI processes and instruments through periodic meetings (supported by QIT team minutes). The QIT identify and report remediation and possible system improvement issues (which is supported through a QI Action Plan Form).

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Uniform Assessment Instrument Report:
Nurse Manager and Program Manager (NM, PM), address/change/remediate specific performance issues with the appropriate staff.

Internal File Audit:
The internal file audits are completed by the Nurse Manager or Program Manager. The Nurse Manager and Program Manager address specific performance issues with individual staff. Any miscalculation in service units is corrected at the time of remediation.

QA Processes and Instruments:
Nurse Manager and Program Manager (NM, PM) remediate any specific performance issues with the appropriate staff as needed and annually. Nurse Reviewers and Support Staff are encouraged to provide feedback on QA instruments and processes on a routine basis.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

When an individual is determined to be likely to require nursing facility level of care, the nurse reviewer informs the individual or his or her legal representative of feasible alternatives under the waiver, and presents the choice of either institutional or home and community-based services. The nurse reviewer answers questions asked by the participant (and/or family or legal representative, as appropriate).

At the time of initial contact to set the assessment time with an applicant, the nurse reviewer provides the applicant with information about waiver services. Prior to conducting the level of care assessment, the nurse reviewer will provide the participant (and/or family or legal representative, as appropriate) information about the A & D waiver, including explaining living options (i.e. nursing facility, certified family home, residential assisted living facility, or in their own home). The participant chooses services and providers by signing the Service and Provider Choice form. This form allows the individual to agree to the waiver services identified in the assessment, acknowledge the living arrangement they have chosen, and to accept or decline the waiver service in lieu of nursing facility placement. The participant (and/or family or legal representative, as appropriate) makes a choice of providers and services annually at redetermination.

For participants enrolled in the MCE, the MMCP Care Coordinator or Idaho Medicaid Plus Care Specialist reviews the MCE equivalent of the Service and Provider Choice form with the participant and retains the signed form. The Care Coordinator is responsible for providing information about A&D waiver services to MMCP enrollees, and the Care Specialist is responsible for providing information about A&D waiver services to Idaho Medicaid Plus enrollees.

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

Copies of the Service and Provider Choice form or the MCE's equivalent form are maintained by Medicaid or the MCE, as applicable, for five years.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The following are the Department of Health & Welfare's methods to ensure meaningful access to the waiver related to Limited English Proficiency:

1. It is the Department's goal to ensure persons with limited English skills (language, hearing, or other sensory impairment) can effectively access its health and human services. More specifically, the Department and the MCE provide effective communications with clients who have limited English proficiency (LEP), are deaf/hard of hearing or are blind, and to ensure interpreter services are provided to these clients on a need type basis at no cost to them.

2. The MCE shall adopt methods and procedures that guarantee each participant enrolled in the MMCP or Idaho Medicaid Plus the right to receive information, including but not limited to: all enrollment notices, informational materials, and instructional materials in a manner and format that may be easily understood.

3. The Directory of Communication Resources lists sources available to help staff obtain the assistance needed when communicating with persons who are limited in their communication ability. The External Resources Section of the Directory can also help staff locate communication assistance. Listed in this section are brief overviews of the Over-the-Phone Interpretation Services, the Idaho Relay Service, and other organizations. The Civil Rights Manager is also available to provide assistance in obtaining services. This Directory is offered simply as a communication aid. Staff are encouraged to refer to the Department's Procedure for Obtaining Interpreter and Translation Services. If staff have a question about this procedure, they are to ask their immediate supervisor. If further assistance is needed, they may contact the Department's Civil Rights Manager.

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

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

c. Sign Language
Network Interpreting Service (NIS) - schedule sign language interpreters for a fee (1-800-284-1043). To identify the local sign language interpreting services available in the area, refer to Regional Off-Site Resources in the Department's Directory of Interpreter/Communication Resources.
The Department's Division of Human Resources maintains a list of Department staff and external individuals available for translation assistance. This list is maintained on the Department's Intranet.

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

The 2-1-1 Idaho CareLine is a toll-free, statewide service available to link Idahoans with health or human service providers and programs and has translation assistance services.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Health**		
Statutory Service	**Day Habilitation**		
Statutory Service	**Homemaker**		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Extended State Plan Service	**Attendant Care**		
Other Service	**Adult Residential Care**		
Other Service	**Chore Service**		
Other Service	**Companion Services**		
Other Service	**Consultation**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Home Delivered Meals**		
Other Service	**Non-medical Transportation**		
Other Service	**Personal Emergency Response System**		
Other Service	**Skilled Nursing**		
Other Service	**Specialized Medical Equipment and Supplies**		
Other Service	**Transition Services**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04060 adult day services (social model)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

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

Adult day health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments.

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

Participants residing in a home based setting may only receive adult day health care services twelve hours in any 24-hour period. Participants residing in a certified family home may only receive adult day health care services if there is an assessed unmet socialization need that cannot be provided by the certified family home provider. Adult day health care services are not offered to participants who reside in a Residential Assisted Living Facility.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Health Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Adult Day Health. Providers of adult day health must meet the following requirements:

a. Services provided in a facility must meet the building and health standards identified in IDAPA 16.03.21, Developmental Disabilities Agencies (DDA).
b. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, Rules Governing Certified Family Home.
c. Services provided in a Residential Adult Living Facility must meet the standards identified in IDAPA 16.03.22, Residential Care or Assisted Living Facilities in Idaho.
d. Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, Criminal History and Background Checks
e. Adult day health providers who provide direct care or services must be free from communicable disease.
f. All providers of adult day health services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff. IDAPA 16.03.10.329.03. "Provider Qualifications."

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Certified Family Home Management/RALF/Medicaid/MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**

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

Service Definition *(Scope):*

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

Day habilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day habilitation services will focus on enabling the participant to attain or maintain his or her maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

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

Limited to 30 hours a week.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Habilitation Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Habilitation Agency

Provider Qualifications

License *(specify):*

Standard licensing specific to their discipline.

Certificate *(specify):*

Other Standard *(specify):*

Providers of day habilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. Day habilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare and MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition (Scope):

Homemaker services consist of performing for the participant, or assisting him with, or both, the following tasks: laundry, essential errands, meal preparation, and other routine housekeeping duties if there is no one else in the household capable of performing these tasks.

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

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Assistance Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:

Personal Assistance Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks. All providers of homemaker must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff. IDAPA 16.03.10.329.03. "Provider Qualifications."

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08010 home-based habilitation
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

i. Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities;
ii. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations;
iii. Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures;
iv. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature;
v. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; or
vi. Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs.
vii. Personal Assistance Services, necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the person or the person's primary caregiver(s) are unable to accomplish on his or her own behalf. Personal assistance activities include direct assistance with grooming, bathing, and eating, assistance with medications that are ordinarily self-administered; supervision; communication assistance, reporting changes in the waiver participants condition and needs; household tasks essential to health care at home to include general cleaning of the home, laundry, meal planning and preparation, shopping, and correspondence.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Habilitation Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Residential Habilitation Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

As described in IDAPA 16.03.10.329.18 Providers of residential habilitation services must be at least eighteen (18) years of age; Be a high school graduate or have a GED or demonstrate the ability to provide services according to a plan of care; Have current CPR and First Aid certifications; Be free from communicable diseases.

Other Standard *(specify):*

Residential Habilitation -- Supported Living. When residential habilitation services are provided by an agency, the agency must be certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, Rules Governing Residential Habilitation Agencies, and supervise the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements:
a. Direct service staff must meet the following minimum qualifications:
i. Be at least eighteen (18) years of age;
ii. Be a high school graduate, or have a GED, or demonstrate the ability to provide services according to a plan of service;
iii. Have current CPR and First Aid certifications;
iv. Be free from communicable diseases;
v. Each staff person assisting with participant medications must successfully complete and follow the Assistance with Medications course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. Staff previously trained on assistance with medications by a licensed nurse but who have not completed this course must meet this requirement by July 1, 2007.
vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.
vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department.
b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant.
c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-29-12)
i. Purpose and philosophy of services;
ii. Service rules;
iii. Policies and procedures;
iv. Proper conduct in relating to waiver participants;
v. Handling of confidential and emergency situations that involve the waiver participant;
vi. Participant rights;
vii. Methods of supervising participants;
viii. Working with individuals with developmental disabilities; and
ix. Training specific to the needs of the participant.
x. Working with individuals with traumatic brain injuries
e. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum:
i. Instructional techniques: Methodologies for training in a systematic and effective manner;
ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors;
iii. Feeding;
iv. Communication;
v. Mobility;
vi. Activities of daily living;
vii. Body mechanics and lifting techniques;
viii. Housekeeping techniques; and
ix. Maintenance of a clean, safe, and healthy environment.
f. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Respite Care. Short-term breaks from care giving responsibilities to non-paid care givers. The care giver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. Respite care services may be provided in the participants residence, a Certified Family Home, a Developmental Disabilities Agency, a Residential Assisted Living Facility, and an Adult Day Health Facility.

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

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

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

☒ **Provider managed**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:

Respite Care Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Respite. Providers of respite care services must meet the following minimum qualifications:
a. Have received care giving instructions in the needs of the person who will be provided the service;
b. Demonstrate the ability to provide services according to a plan of service;
c. Be free of communicable diseases; and
d. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.
e. Training requirements contained in the Idaho provider training matrix and standards for direct care staff as required by IDAPA 16.03.329.03

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Personal Assistance Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Respite. Providers of respite care services must meet the following minimum qualifications:
a. Have received care giving instructions in the needs of the person who will be provided the service;
b. Demonstrate the ability to provide services according to a plan of service;
c. Be free of communicable diseases; and
d. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.
e. Training requirements contained in the Idaho provider training matrix and standards for direct care staff as required by IDAPA 16.03.329.03

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work.

a. Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA.
b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employers participation in a supported employment program, payments that are passed through to beneficiaries of a supported employment program, or payments for vocational training that are not directly related to a waiver participant's supported employment program.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Supported Employment. Supported Employment services must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks. Providers must take a traumatic brain injury training course approved by the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Attendant Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically oriented tasks dealing with the functional needs of the participant and accommodating the participants needs for long-term maintenance, supportive care, or activities of daily living (ADL). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to an unlicensed person by a health care professional or the participant. Services are based on the person's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Attendant care services are provided when personal care services furnished under the approved State plan limits are exhausted.
Services and equipment that are available through the Medicaid State plan as 1905(a) services for children per Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements are not allowed as payable under Attendant Care services. Experimental or prohibited treatments are excluded.

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

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Assistance Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Attendant Care

Provider Category:

Agency

Provider Type:

Personal Assistance Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.

All providers of attendant care must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with IDAPA 16.03.10.329.03, "Provider Qualifications."

Verification of Provider Qualifications

Entity Responsible for Verification:

Idaho Department of Health and Welfare and MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Residential Care

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02023 shared living, other
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Adult Residential Care Services. Adult residential care services consist of a range of services provided in a homelike, non-institutional setting that include residential care or assisted living facilities and certified family homes. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

a. Adult residential care services consist of a range of services provided in a congregate setting licensed under IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," that include:

i. Medication assistance, to the extent permitted under State law;
ii. Assistance with activities of daily living;
iii. Meals, including special diets;
iv. Housekeeping;
v. Laundry;
vi. Transportation;
vii. Opportunities for socialization;
viii. Recreation; and
ix. Assistance with personal finances.
x. Administrative oversight must be provided for all services provided or available in this setting.
xi. A written individual service plan must be negotiated between the participant or his legal representative, and a facility representative.

b. Adult residential care services also consist of a range of services provided in a setting licensed under IDAPA 16.03.19, "Rules Governing Certified Family Homes," that include:

i. Medication assistance, to the extent permitted under State law;
ii. Assistance with activities of daily living;
iii. Meals, including special diets;
iv. Housekeeping;
v. Laundry;
vi. Transportation;
vii. Recreation; and
viii. Assistance with personal finances.
ix. Administrative oversight must be provided for all services provided or available in this setting.
x. A written individual service plan must be negotiated between the participant or his legal representative, and a facility representative.

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

Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Family Home
Agency	Residential Assisted Living Facilities

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Residential Care

Provider Category:
Agency
Provider Type:

Certified Family Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified Family Home certificate as described in Idaho Administrative Code at IDAPA 16.03.19.110. A certificate is valid for no more than twelve (12) months from the date of approval.

Other Standard *(specify):*

Adult residential care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of
the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," or IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

All providers of adult residential care, must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff. IDAPA 16.03.10.329.03. "Provider Qualifications."

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Every twelve months.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Residential Care

Provider Category:

Agency

Provider Type:

Residential Assisted Living Facilities

Provider Qualifications

License *(specify):*

Licensed by Department

Certificate *(specify):*

License is required for all Residential Assisted Living Facilities in Idaho, as described in IDAPA 16.03.22.100

Other Standard *(specify):*

Adult residential care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of
the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," or IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

All providers of adult residential care, must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff. IDAPA 16.03.10.329.03. "Provider Qualifications."

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Every one (1) to three (3) years, depending on performance in the prior visit.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Chore Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Chore Services. Chore services include the following services when necessary to maintain the functional use of the home, or to provide a clean, sanitary and safe environment:

a. Intermittent Assistance may include the following.
i. Yard maintenance;
ii. Minor home repair;
iii. Heavy housework;
iv. Sidewalk maintenance; and
v. Trash removal to assist the participant to remain in their home.

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

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

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

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

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Assistance Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Service

Provider Category:
Agency
Provider Type:

Personal Assistance Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Chore Services. Providers of chore services must meet the following minimum qualifications:

a. Be skilled in the type of service to be provided; and
b. Demonstrate the ability to provide services according to a plan of service.
c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.
d. Meet, either by formal training or demonstrated competency, the training requirements in the Idaho provider training matrix and the standards for direct care staff. IDAPA 16.03.10.329.03. "Provider Qualifications."

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Companion Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion

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

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

Service Definition *(Scope):*

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

Companion Services. Companion services include non-medical care, supervision, and socialization provided to a functionally impaired adult. Companion services are in-home services to ensure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider, who may live with the participant, may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. However, the primary responsibility is to provide companionship and be there in case they are needed.

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

Companion services are not authorized for participants living in Certified Family Homes or Residential Assisted Living Facilities. Companion services do not include room and board.

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Assistance Agency
Individual	Individual Persons

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Agency

Provider Type:

Personal Assistance Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

All providers of companion services must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's Aged and Disabled waiver as approved by CMS. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.

See IDAPA 16.03.10.329.03. "Provider Qualifications."

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Companion Services

Provider Category:

Individual

Provider Type:

Individual Persons

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

All providers of companion services must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's approved Aged and Disabled waiver as approved by CMS. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks."

See IDAPA 16.03.10.329.03. "Provider Qualifications."

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Consultation services are services to a participant or family member. Services are provided by a Personal Assistance Agency to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self-reliance possible for the participant and the participant's family. Services include consulting with the participant and family to gain a better understanding of the special needs of the participant and the role of the caregiver.

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

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Assistance Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultation

Provider Category:

Agency

Provider Type:

Personal Assistance Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Consultation services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Environmental accessibility adaptations include minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include:

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning.
b. Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home that is the participants principal residence, and is owned by the participant or the participants non-paid family.
c. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptations

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Certificates are required when mandated by State or local building codes for particular types of environmental accessibility adaptations. For instance, a provider must have a plumbing license to be permitted to complete plumbing work

Other Standard *(specify):*

All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification.

Environmental Accessibility Adaptions are delivered through an executed provider agreement with the provider and Medicaid, or, in the case of MMCP enrollees, through an executed provider agreement with the provider and the MCE. Providers are reviewed during the initial provider agreement approval process and when services are authorized.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Verified with initial Provider Agreement and when services are authorized

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Environmental Accessibility Adaptations

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Certificates are required when mandated by State or local building codes for particular types of environmental accessibility adaptations.

Other Standard *(specify):*

All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification.

Environmental Accessibility Adaptions are delivered through an executed provider agreement with the provider and Medicaid, or, in the case of MMCP enrollees, through an executed provider agreement with the provider and the MCE. Providers are reviewed during the initial provider agreement approval process and when services are authorized.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Verified with initial Provider Agreement and when services are authorized

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Home Delivered Meals are meals that are delivered to the participant's home to promote adequate participant nutrition. One (1) or two (2) meals per day may be provided to a participant who:

a. Rents or owns a home;
b. Is alone for significant parts of the day;
c. Has no regular caretaker for extended periods of time; and
d. Is unable to prepare a balanced meal without assistance.

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Delivered Meals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of home delivered meals must be a public agency or private business, and must exercise supervision to ensure that:

a. Each meal meets one-third (1/3) of the recommended daily allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences;
b. Meals are delivered in accordance with the service plan, in a sanitary manner, and at the correct temperature for the specific type of food;
c. Documentation is maintained demonstrating that the meals served are made from the highest USDA grade for each specific food served;
d. The agency or business is inspected and licensed as a food establishment by the district health department;
e. Registered Dietitian documented review and approval of menus, menu cycles, and any changes or substitutes is maintained; and
f. Either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule have been met.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-medical Transportation

HCBS Taxonomy:

Category 1: 15 Non-Medical Transportation

Sub-Category 1: 15010 non-medical transportation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Non-medical Transportation. Non-medical transportation enables a waiver participant to gain access to waiver and other community services and resources.

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

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Commercial Transportation Agencies

Provider Category	Provider Type Title
Individual	Residential Assisted Living Facility
Agency	Certified Family Home

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:

Commercial Transportation Agencies

Provider Qualifications

License *(specify):*

Driver's License

Certificate *(specify):*

Other Standard *(specify):*

Non-Medical Transportation Services. Providers of non-medical transportation services must:

a. Possess a valid drivers license;
b. Possess valid vehicle insurance; and
c. Meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with IDAPA 16.03.10.329.03.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department and MCE

Frequency of Verification:

Verified with initial provider application.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:

Residential Assisted Living Facility

Provider Qualifications

License *(specify):*

Driver's License

Certificate *(specify):*

Other Standard *(specify):*

Non-Medical Transportation Services. Providers of non-medical transportation services must:

a. Possess a valid drivers license;
b. Possess valid vehicle insurance; and
c. Meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with IDAPA 16.03.10.329.03.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department and MCE

Frequency of Verification:

Verified with initial provider application, and at least once every three years after the initial provider application.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Certified Family Home

Provider Qualifications

License *(specify):*

Driver's License

Certificate *(specify):*

Other Standard *(specify):*

Non-Medical Transportation Services. Providers of non-medical transportation services must:

a. Possess a valid driver's license;
b. Possess valid vehicle insurance; and
c. Meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with IDAPA 16.03.10.329.03.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department and MCE

Frequency of Verification:

Annual

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

PERS is an electronic device that enables a waiver participant to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participants phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. Installation of the equipment is provided and separately billable to Medicaid. Maintenance and upkeep is furnished by the supplier.

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

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

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

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response System

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:

Personal Emergency Response System

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Personal emergency response system providers must demonstrate that the devices installed in a waiver participant's home meets Federal Communications Standards, or Underwriter's Laboratory standards, or equivalent standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Skilled Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho.
Services and equipment that are available through the Medicaid State plan as 1905(a) services for children per Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements are not allowed as payable under Skilled Nursing services. Experimental or prohibited treatments are excluded.

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

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

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

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

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Assistance Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Personal Assistance Agency

Provider Qualifications

License *(specify):*

Skilled nursing service providers must be licensed in Idaho as a registered nurse or licensed practical nurse in Idaho good standing, or must be practicing on a federal reservation and be licensed in another state. Skilled nursing providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, Criminal History and Background Checks.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized Medical Equipment and Supplies.

a. Specialized medical equipment and supplies include:
i. Devices, controls, or appliances that enable a participant to increase his abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which he lives; and
ii. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.

b. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State plan and exclude those items that are not of direct medical or remedial benefit to the participant.

Maintenance and upkeep of equipment purchased under this benefit category may be included, and is evaluated on a case-by-case basis.

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Medical Equipment and Supplies

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Specialized Medical Equipment and Supplies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. Providers must ensure all items must meet applicable standards of manufacture, design and installation. Preference will be given to equipment and supplies that are the most cost effective option to meet the participants needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health & Welfare and MCE

Frequency of Verification:

Verified with initial provider agreement

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transition Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transition Services: Transition Services include non-recurring set-up expenses that enable a participant residing in a nursing facility, hospital, Institution for Mental Diseases (IMD), or Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) to transition to a community-based setting where the person is directly responsible for his or her own living expenses. A participant is eligible to receive Transition Services immediately following discharge from a qualified institution after residing within that institution for a minimum of forty-five (45) Medicaid-reimbursed days.

IDAPA 16.03.10.326.17, Transition Services, lists the qualified institutions as the following:
- Skilled, or Intermediate Care Facilities;
- Nursing Facility;
- Licensed Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID);
- Hospitals; and
- Institutions for Mental Diseases (IMD).

IDAPA 16.03.10.326.17, Transition Services, lists the following allowable non-recurring set-up expenses:
o Security deposits that are required to obtain a lease on an apartment or home;
o Cost of essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens;
o Set-up fees or deposits for utility or service access, including telephone, electricity, heating, and water;
o Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
o Moving expenses; and
o Activities to assess need, arrange for, and procure transition services.

Allowable expenses are those necessary to enable a person to establish a basic household, and that do not constitute room and board.

Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the Service Plan development process, clearly identified in the Service Plan, and the person is unable to meet such expense or when the support cannot be obtained from other sources.

Transition Services do not include monthly rent or mortgage expenses, food, household appliances, ongoing recurring expenses, real property, ongoing utility changes, décor, and/or items specifically for diversion/recreational purposes.

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

Transition Services are limited to a total cost of $2,000 per participant and can only be accessed every two years, contingent upon a qualifying transition from an institutional setting.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Assistance Agency
Agency	Transition Manager

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Agency

Provider Type:

Personal Assistance Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Transition Managers are responsible for administering Transition Services. All providers of Transition Services must:

• Satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, “Criminal History and Background Checks”; and

• Have documented successful completion of the Department-approved Transition Manager Training prior to providing any Transition Management and/or Transition Services; and

• Have a Bachelor’s Degree in a Human Services field from a nationally accredited university or college; or three (3) years’ supervised work experience with the population being served; and

• Be employed with a provider type approved by the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare and MCE

Frequency of Verification:

Every two years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Agency

Provider Type:

Transition Manager

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Transition managers provide oversight and coordination activities for participants during a transitional period up to twelve (12) months following a return to community. This provider type will function as a liaison between the participant, institutional or facility discharge staff, and the Department to support a successful and sustainable transition to the community. A participant is eligible to receive transition management when planning to discharge from a qualifying institution after residing within that institution for a minimum of forty-five (45) Medicaid-reimbursed days.

Transition Managers must:
1. Satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks".
2. Have documented successful completion of the Department approved Transition Manager training prior to providing any transition management and transition services.
c. Have a Bachelor's Degree in a human services field from a nationally accredited university or college, or three (3) years' supervised work experience with the population being serviced; and
d. Be employed with a provider type approved by the Department.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare and MCEs

Frequency of Verification:

At least every two years

Appendix C: Participant Services

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

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

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

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Appendix C: Participant Services

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

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

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

◉ **Yes. Criminal history and/or background investigations are required.**

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

a. Homemaker, attendant care, adult day health, habilitation, residential habilitation, day habilitation, supported employment, respite, chore services, consultation, adult residential care, companion services, skilled nursing, and transition services.

b. The criminal history check is a fingerprint-based check consisting of a self-declaration, fingerprints of the individual, information obtained from the Federal Bureau of Investigation, the National Criminal History Background Check System, Bureau of Criminal Identification, the Statewide Child Abuse Registry, Adult Protection Registry, Sexual Offender Registry, and Medicaid SURs exclusion list. Done in accordance with Idaho Administrative Code at IDAPA 16.05.06.100 & 170, Rules Governing Mandatory Criminal History Checks.

c. Quality improvement audits of provider records ensure compliance. Non-compliance will result in recoupment. Any individual who requires a check shall complete a criminal history check, including fingerprints, when he accepts employment with a new employer or agency providing Department funded direct care or services and his last criminal history check was completed more than three years from the date of the new employment. It is the providers responsibility (including FI agencies) to ensure the employee has either the department approved self declaration or a department approved background clearance prior to service delivery.

The quality improvement specialist completes provider quality improvement reviews every 2 years to assure criminal history checks are completed on employees. The quality improvement specialist complete a random sampling of participants records to be reviewed. At least 10% of the provider's participant files or a minimum of 4 records are reviewed. If the provider has less than 4 participants 100% of the records will be reviewed. The quality improvement specialist will review the provider employee files that provided care for the participant records selected. The quality improvement specialist will review the employee records to ensure a self declaration or clearance is in the file and employee was approved by the criminal history unit to provide services.

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

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

(a)The Idaho Department of Health & Welfare Division of Family & Childrens Services is responsible for maintaining the Child Abuse Registry. The Adult Protection Registry is maintained by Idaho Commission on Aging.

(b)Criminal history checks outlined above include review of the abuse registries. The positions that require abuse registry screening are the same as positions requiring criminal history checks. Abuse registry screening is included in the criminal history check process outlined above.

Appendix C: Participant Services

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

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

◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

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

◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

☐ **Self-directed**

☐ **Agency-operated**

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

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3 except for spouses. There are numerous safeguards in place to ensure that payments are only made for services rendered including oversight by provider agencies, person-centered planning teams, circles of supports, and by the Department through review and approval of proposed plans of care and retrospective quality assurance reviews. Spouses are not eligible to receive payment for services provided. The A&D Waiver does not permit individual persons to be paid caregivers under the waiver. All individuals, including relatives and legal guardians, must be employees of an agency in order to furnish services to participants. This ensures that all relatives and legal guardians meet the same standards for quality of service delivery – and are subject to the same oversight for prevention of abuse, neglect, and exploitation – as non-relative caregivers. Both provider agencies and the state have oversight.

Provider claims for participant services are edited against the eligibility file in MMIS to ensure claims are paid for Medicaid eligible participants only.

In addition, the Medicaid Fraud & Program Integrity Unit (MPIU) conducts ongoing utilization reviews by categorizing all providers by type and specialty, ranking them in categories and doing a peer grouping analysis and comparing provider billing patterns against their peers. It ranks probable abusive patterns from most to least abuse. MPIU staff review these ranking reports and initiates follow-up reviews when warranted.

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

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

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers

have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

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

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

Under 1915(a) authority, the MCE may limit providers. The Department will ensure that the MCE meets the access network adequacy standards required in the contract. However, the MCE may limit the number of providers it accepts so long as the network adequacy standards are met.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of ongoing waiver providers that meet licensure or certification standards, including training requirements. a. Numerator: Number of ongoing waiver providers that meet licensure or certification standards, including training requirements. b. Denominator: Number of ongoing waiver providers surveyed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Provider Agency Review Report BLTC QIS Summary

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of initial, licensed/certified waiver providers that meet licensure or certification standards, including training requirements. a. Numerator: Number of initial waiver providers that meet licensure or certification standards, including training requirements, prior to providing services. b. Denominator: Number of initial waiver providers requiring licensure or certification.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The Division of Licensing and Certification is responsible for licensing or certifying all waiver providers subject to licensure or certification requirements.

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of non-licensed/non-certified waiver providers who received a

quality review every two years. a. Numerator: Number of non-licensed/non-certified waiver providers that received a quality review every two years. b. Denominator: Number of non-licensed/non-certified waiver providers required to receive a quality review in the waiver year.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Provider Agency Review Report Quarterly BLTC QIS Summary

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of initial, non-licensed/non-certified providers that received an initial provider review within 6 months of providing waiver services. a. Numerator: Number of initial, non-certified/non-licensed providers that received a review within 6 months of providing waiver services. b. Denominator: Number of initial, non-certified/non-licensed providers.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Initial Provider Review Reports

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of initial, non-licensed/non-certified waiver providers that received Department training prior to providing services. a. Numerator: Number of initial, non-licensed/non-certified waiver providers that received Department training prior to providing services. b. Denominator: Number of initial, non-licensed/non-certified waiver providers.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:
Provider Training Report

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

Data Aggregation and Analysis:

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

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

Provider Enrollment:
The Quality Improvement Specialist (QI Specialist) or designee reviews the application packet which may include reviewing the provider's policies and procedures and recommends the approval or denial of initial provider application. Providers are required to attend a department training prior to delivering waiver services to participants.

Medicaid Central Office compiles information from the Provider Agency Review Tracking Tool and gathers data for the number of initial applications received and number approved. This data is compiled in a quarterly report.

Provider Reviews:
The Quality Improvement Specialist (QI Specialist) or designee conduct provider reviews every two years and enters the results in the Provider Agency Review Tracking Tool. The QI Specialist works with non-compliant providers on plans of correction and recommends appropriate provider sanctions or actions when applicable.

Medicaid Central Office compiles information from the Provider Agency Review Tracking Tool and gathers data for the number of providers due and the number of providers completed. This data is compiled in a quarterly report.

Provider Training:
The Quality Improvement Specialists (QI Specialists) provide initial training for all new waiver providers. Ongoing provider trainings may be provided as concerns are identified from Provider Agency Reviews or Nurse Reviewer Home Visits. The QI Specialists are responsible for 1:1 provider training and technical assistance, in addition to remediation for participant specific complaints/critical incidents and statewide provider trainings for program-wide changes or system improvement processes identified by the Bureau of Long Term Care Committee (BLTCC) or designee.

Medicaid Central Office completes an analysis of the provider data on a quarterly basis and reports to the BLTCC or designee.

Participant Experience Data:
The participant experience questions on the Quality Survey provides HCBS participants (and/or family or legal representative, as appropriate) with the opportunity to provide feedback to the Department regarding Medicaid HCBS providers. Participant experience response data are entered in the BLTC Data Management Tool. The nurse reviewer home visit data is analyzed on a quarterly basis and reported to the BLTCC or designee.

MCE Oversight:
The Department contract monitor will oversee operations of the MCE, and ensure compliance with all terms of the contract that pertain to Aged and Disabled Waiver participants. The MCE is subject to remedies for violations of contractual requirements. The MCE must provide a Provider Network Report, including a Provider Enrollment File, on a quarterly basis for review by the Department. The report shall include information on all Providers of services outlined in the contract, including HCBS providers. The IDHW Contract Monitor ensures that the MCE has enrolled HCBS providers in sufficient number and type to meet the needs of waiver participants that have enrolled in the MMCP. All providers that enroll with the MCE to serve MMCP waiver participants must first be enrolled with Idaho Medicaid as providers in good standing. The BLTC has in place policies and procedures to immediately notify the MCE in the event of a terminated provider agreement for a provider that also serves MCE enrollees.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Provider Reviews:
The Quality Improvement (QI) Team reviews provider review processes, instruments or concerns through periodic meetings (supported by QI team minutes). QI team submits recommendations for QI to BLTCC or designee. The BLTCC identifies and addresses statewide resource or program issues identified in the analysis of this information. The results of this analysis are documented in BLTCC meeting minutes and recommended program changes or system improvement processes are sent to the Bureau Leadership Team (BLT) for consideration.

Provider Enrollment:
The Quality Improvement (QI) Team reviews the provider enrollment process, initial provider trainings or concerns through periodic conference calls (supported by QI team minutes). The BLTCC identifies and addresses statewide provider enrollment issues identified in the analysis of this information. The results of this analysis are documented in the BLTCC minutes and recommended provider enrollment changes are submitted to the Medicaid Quality Management Oversight Committee for consideration.

The Medicaid Quality Management Oversight Committee reviews BLTCC and other Medicaid program report analysis and recommendations, considers Division-wide resources, coordination issues and strategies to make final system-wide change decisions.

Provider Training:
The BLTCC identifies and addresses statewide provider issues identified in the analysis of this information. The result of this analysis is reported through the BLTCC minutes and recommended provider training changes are sent to the Medicaid Quality Management Oversight Committee for approval.

The BLT reviews BLTCC and other Medicaid program report analysis and recommendations, considers Division-wide resources, coordination issues and strategies to make final system wide change decisions.

Participant Experience Data:
The BLTCC identifies and addresses statewide provider issues identified in the analysis of participant experience data. The results of this analysis are documented in BLTCC minutes and recommended provider training changes are submitted to the Medicaid Quality Management Oversight Committee for approval. The BLT reviews BLTCC and other Medicaid program report analysis and recommendations, considers Division-wide resources and coordination issues and strategies and makes final system-wide change decisions.

MCE Oversight:
The MCE utilizes the same sampling methods as IDHW for performance and quality improvement measures. The MCE will remediate problems that arise related to the MCE and waiver participants as needed. If needed, the contract monitor may pursue remedies specified in the terms of the Department's contract with the MCE.

The IDHW Contract Monitor will issue a Monitoring Report to the MCE that identifies in writing the Performance Indicator(s) monitored, and that summarizes the preliminary results with the MCE. Upon request by the MCE, IDHW will meet with the MCE within ten (10) business days of their receipt of the Monitoring Report regarding the results. The MCE may dispute the findings via written appeal to the Contract Monitor within ten (10) business days of issuance of the report. The MCE must specifically address each disputed finding and justification for the appeal of the finding. The MCE is required to provide all documents necessary to dispute monitor results with its written appeal. IDHW will render a final written decision on the appeal to the MCE within ten (10) business days of receipt of the MCE's dispute information, unless the parties agree in writing to extend the decision period.

If the MCE does not dispute the findings, the MCE shall have ten (10) business days from the date of IDHW's monitoring report to cure the deficiencies found. If the MCE appeals the monitoring report, the MCE shall have ten (10) business days from the date of IDHW's final written decision to cure the deficiencies. If IDHW is not satisfied that the MCE has resolved the deficiencies, or made substantial progress toward resolution, IDHW may assess the amounts listed in the Scope of Work as liquidated damages for each day the deficiency remains uncured.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the

amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

See Attachment #2.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [x] **Registered nurse, licensed to practice in the state**
- [x] **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- [ ] **Social Worker**
  Specify qualifications:
- [ ] **Other**
  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

a. To support the participant (and/or family or legal representative, as appropriate)in the direction and active involvement in the service plan development process the following supports and information are made available:

1. The nurse reviewer or MCE Care Coordinator provides a copy of the "Service and Provider Choice" form or the MCE's equivalent form, if applicable, to the participant (and/or family or legal representative as appropriate). The form outlines the assistance needed as identified during the assessment and any additional waiver services needed. The participant (and/or family or legal representative, as appropriate) is asked to specify the place of service at this time (their own home, a certified family home, a residential assisted living facility, etc.). In instances where the participant has not identified a provider at the time of the assessment, they may complete and return the "Service and Provider Choice" form to the Department or the MCE after selecting their preferred provider(s) of services.

2. Lists of service providers are given to the participant (and/or family or legal representative, as appropriate). These lists contain those providers with current valid provider agreements with the Department (or, as applicable, the MCE). The Department of Health & Welfare maintains several booklets about long-term services and supports, choosing a provider, and identifying a place to live and these are made available to the participant (and/or family or legal representative, as appropriate). The MCE will maintain an up-to-date searchable Provider Directory on its website. In 2016 the Department plans to develop a new booklet regarding participant rights, including their person-centered planning rights.

3. The participant (and/or family or legal representative as appropriate) retains the authority to determine who attends the service planning meetings. The planning meeting should include at a minimum, the participant (and/or family or legal representative, as appropriate), the provider (RN or LPN) and others identified by the participant. The Nurse Reviewer informs the participant (and/or family or legal representative as appropriate) that they may have anyone attend the meeting to assist them. The service planning meetings typically occur in the participant's current living arrangement which facilitates the attendance of family, guardian, or legal representative.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

1. Upon initial application and thereafter yearly at reassessment a Uniform Assessment Instrument (UAI) is administered by a Department nurse reviewer to identify the level of care and unmet needs of each participant. A participant's family or legal representative and caregiver(s) may also be present and supply information if desired by the participant. Caregivers, facility staff, or others may contribute information or be called by Nurse Reviewers (NR) to aid in completing the assessment.

2. The nurse reviewer uses the MMIS system (or, as applicable, the MCE nurse uses the MCE's system) to check other Medicaid services used for cost effectiveness and for coordination of services. The participant (and/or family or legal representative, as appropriate) is consulted on choice of services. The "Service and Provider Choice," or the MCE's equivalent form, is a form that shows all the services offered under the waiver. Based on the UAI responses, the services for which the participant is eligible are identified on the form. This form is used as the basis for discussion with the participant (and/or family or legal representative, as appropriate) about which services they would like to receive and which providers they would like to select to furnish those services.

3. In discussion with the participant (and/or family or legal representative, as appropriate), the staff documents which services the participant (and/or family or legal representative, as appropriate) has chosen and number of hours or units needed. These units/hours are incorporated into the UAI Support Plan and will calculate NF Level of Care points, weekly/monthly units, daily rates, monthly costs, and determine cost effectiveness. The Support Plan is the basis of the Individual Service Plan. For MMCP enrollees, the completed UAI is transmitted to the MCE registered nurse to be included as part of the participant's Individualized Care Plan.

4. For fee-for-service participants, this information is then sent to the provider (agency, certified family home, or residential assisted living facility, etc.) chosen by the participant (and/or family or legal representative, as appropriate). The provider is responsible for the completion of the service plan that is to be used by caregivers to provide services to meet the assessed needs and to address the strengths and preferences of the participant. The service plan must contain at a minimum the following components:
a. For In-Home services the service plan must be developed by an RN. Residential Assisted Living Facilities must have an RN on staff or contract who is involved in the development of the service plan when applicable. Certified Family Home providers must develop a plan that is approved by the BLTC NR (all BLTC NRs are RNs) prior to service authorization to ensure the plan is appropriate.
b. The participant (and/or family or legal representative, as appropriate) must participate in the development of the service plan.
d. The service plan must include the details of how all the needs of the participant will be met, including those that will be met by natural supports or other provider entities. Sufficient detail must be in the plan for the caregiver to know participant preferences, level of assistance needed, amount, scope and duration for each task.
e. The service plan must include the goals of the participant and how they will be met.
f. The service plan must include an assessment of any risks that may interfere with the participant's needs being met and/or potential health and safety issues and a back-up plan to meet those needs. In the event of health or safety risks associated with the home and community-based setting requirements described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," the service plan must also reflect corresponding risk mitigation strategies.
g. For Certified Family Home or Residential Assisted Living Facility participants who, due to health or safety needs, require an exception to the provider owned or controlled residential setting qualities described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," the service plan must include documentation of the participant's assessed need related to the exception, interventions and supports implemented prior to the exception and prior methods that did not work in addressing the participants needs, a clear description of the intervention, evidence of regular data collection to monitor the effectiveness of the exception, time limits for periodic review to determine if the exception is still necessary, informed consent of the participant, and an assurance of no harm.
h. The service plan must be accepted and signed by the participant (and/or family or legal representative, as appropriate) indicating informed consent. The provider must also sign the plan, indicating they will deliver services according to the authorized plan and consistent with home and community-based requirements.

5) The Department NR reviews the service plan during the redetermination process and requests remediation if the service plan does not meet all required components. For MMCP enrollees, the Care Coordinator also reviews the service plan to ensure compliance with service plan requirements.

6) The service plan must be revised and updated by the service plan team based upon treatment results or a change in the

participant's needs. A new service plan must be developed and approved annually or as a result of changes in the participant's condition. These adjustments must be based on changes in a participant's need(s) or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the service plan is subject to prior authorization by the nurse reviewer or MCE registered nurse. The provider completes a Significant Change/Modification Request Form (or the MCE's equivalent form) and submits it to the nurse reviewer or MCE registered nurse. The nurse reviewer or MCE registered nurse reviews the information and may authorize additional services. The UAI and individual service plan are revised and a copy of the revised UAI and notice of decision are mailed to the provider. The nurse reviewer, MCE registered nurse, or MCE Care Coordinator monitors the participant's service plan and all waivered services throughout the year.

7) The service provider is responsible to notify the Department, MCE, physician or authorized provider and family if applicable, when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the provider's service record. The participant (and/or family or legal representative as appropriate) or other interested party can contact the nurse reviewer or MCE registered nurse and request a new assessment or change in service plan.

8) Person-centered planning. Prior to the initial plan development process, participants are advised that they may invite others to their meeting if desired, and a time and date is selected for the interview. Contact information for the Nurse Reviewer is included in the event that the participant needs to reschedule.

The electronic system that houses the UAI has been revised to include more person-centered topics at the initiation of an assessment interview, rather than at the end (which is how the assessment was originally configured). The updated system includes narrative fields to document participant desired outcomes, strengths, and preferences prior to any discussion of specific functional areas. This helps to establish a personalized framework for the remainder of the assessment process that is focused on the participant.

Corresponding supporting documentation (including the user manual for the UAI and supplemental job aids) describes how to effectively use new fields in the assessment tool during conversation with the participant to help focus the interview. These include examples of appropriate narratives, sample prompting questions, etc.

In addition, the BLTC has engaged in ongoing training with staff to ensure they have the tools and skills needed to solicit the participant's full engagement in the assessment interview and plan development process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The Department and the MCE use the following processes to assure that potential risks are assessed during the service plan development and strategies to mitigate risks are incorporated into the service plan, subject to the participant needs and preferences:

1. The Uniform Assessment Instrument (UAI) is the basis for the service plan. This tool assesses: medical history, ADLs, IADLs, list of medications, vision, hearing, speech, nutrition, cognitive and behavioral functions, assistive devices or medical equipment. If in their own home, the tool also assesses environmental barriers or needs. The nurse reviewer or MCE Care Coordinator/Care Specialist also assesses the participant's potential and perceived health, behavioral and personal safety risks (neglect, abuse, and exploitation, etc.), and ability to live safely in their residence. The nurse reviewer will discuss their concerns with the participant (and/or family or legal representative, as appropriate) after the assessment is completed. The risks identified are documented in the UAI. If the participant (and/or family or legal representative, as appropriate, on behalf of the participant) chooses to live in a Certified Family Home or Residential Assisted Living Facility, they must, by IDAPA rule and state law, meet the needs of the participant. All of the UAI information is considered when the service plan is being developed.

2. The personal assistance agency's nurse (RN or LPN) is responsible for the completion of service plans which reflect, address, and coordinate the participant's waiver service care needs. The service plan is developed by the provider's RN or LPN, participant (and/or family or legal representative, as appropriate), providers and any person(s) that the participant (and/or family or legal representative, as appropriate) wishes to invite. The participant (and/or family or legal representative, as appropriate) is actively involved in determining when and how services identified in the Uniform Assessment Instrument are delivered. The agency's nurse is responsible for assuring the caregiver understands, is capable of implementing the service plan and coordinating services.

3. The agency RN or LPN works with the participant, MCE, guardian and other parties as requested by the participant (and/or family or legal representative, as appropriate) to identify strategies for identified risks and individualized interventions developed in the participant care plan to create a system of services and supports to appropriately address individual needs and preferences and assure health and welfare. Community supports will be outlined in the service plan if required.

4. The service provider must have and implement policies and procedures addressing back-up plans for contingencies such as emergencies, including the failure of an employee to appear when scheduled to provide necessary services when the absence of the service presents risk to the participant's health and welfare.

5. The Department Nurse Reviewer or MCE registered nurse will not approve a service plan if services provided will not be safe and effective. Concerns for health and safety may be addressed by the participant's service planning team, the participant's physician or other health care providers and Medicaid or MCE staff.

6. The service provider is responsible for ensuring that any risks posed to the participant by the home and community-based setting requirements described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," and corresponding mitigation strategies are justified and documented appropriately in the service plan. For residential provider owned or controlled settings, any exceptions to the HCB residential setting requirements must be submitted to the Department (or MCE, for MMCP or Idaho Medicaid Plus participants) for review and approval within 30 days of implementing an exception.

7. The service provider is responsible to notify the department, MCE, physician, and family if applicable, when it becomes aware of any significant changes in the participant's condition. Such notification will be documented in the provider's record. The participant (and/or family or legal representative as appropriate) or other interested party can contact the Department Nurse Reviewer or MCE registered nurse and request a new assessment or change in service plan. The provider is responsible for updating the participant's service plan.

8. The participant's service plan may be adjusted during the year. These adjustments must be based on changes in a participant's need, demonstrated outcomes, or changes in risk factors. Additional assessments or information may be clinically necessary. Adjustment of the service plan is subject to prior authorization by the nurse reviewer or MCE registered nurse. The provider completes a Change/Modification Request Form and submits it to the nurse reviewer or MCE registered nurse. The nurse reviewer or MCE registered nurse reviews the information and may authorize additional services. The UAI and Negotiated Service Agreement are revised and a copy of the revised UAI and notice of decision are mailed to the participant (and/or family or legal representative, as appropriate) and provider.

9. The participant (and/or family or legal representative, as appropriate) may initiate changes to the service plan. The participant (and/or family or legal representative, as appropriate) can contact the personal assistance agency to coordinate the service plan change. If the service plan change will result in a change in authorized services, the participant (and/or family or legal representative, as appropriate) may contact their agency to initiate a significant change request to the department. Also, the participant (and/or family or legal representative, as appropriate) can directly contact their Department Nurse Reviewer or MCE registered nurse who will assist with updating the services and coordinating this information to the personal assistance agency.

10. The Department Nurse Reviewer will review the UAI documentation and the service plan during the annual redetermination and whenever applicable to ensure that participant risks have been documented and interventions developed in the service plan. During provider QI reviews, the QI staff will monitor the provider's records to ensure the staff emergency back up policy is followed if applicable.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants (and/or family or legal representative, as appropriate) are assisted in obtaining information about and selecting from among qualified providers of waiver services by the following processes:

1. The participant (and/or family or legal representative, as appropriate) is provided an alphabetical list of Aged and Disabled waiver providers by the nurse reviewer at the completion of the UAI. The nurse reviewer explains the purpose of the list and their right to choose a provider and answers participant (and/or family or legal representative, as appropriate) questions. The participant (and/or family or legal representative, as appropriate) may contact the nurse reviewer if they require additional assistance with provider selection or to request another provider list.

2. Participants (and/or family or legal representatives), as appropriate) may contact the department any time and request a list of current providers with valid provider agreements that operate in the living area of the participant.

3. The Department will ensure that the MCE will maintain an up-to-date searchable Provider Directory on a website that is available to participants enrolled in the MMCP or Idaho Medicaid Plus.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The following is the process by which the service plan is made subject to the approval of the Medicaid agency:

1. From the UAI assessment information, individual service plan is generated by the Department Nurse Reviewer. The plan is mailed to the personal assistance agencies, certified family home or assisted living providers chosen by the participant (and/or family or legal representative as appropriate).

2. The agency licensed nurse will complete the service plan development process using participant feedback and information from the UAI report. The appropriateness of the plan will be checked during QA review by the QI staff and the nurse reviewer during home visits.

3. All waiver services require prior authorization and must be on the service plan. Certified Family Home providers must submit the plan of care to the nurse reviewer for approval.

4. The participant's service plan may be adjusted during the year. These adjustments must be based on changes in a participant's need, demonstrated outcomes, or changes in risk factors. Additional assessments or information may be clinically necessary. Adjustment of the service plan is subject to prior authorization by the nurse reviewer. The provider completes a Change/Modification Request Form and submits it to the nurse reviewer. The reviewer reviews the information and may authorize additional services. The UAI and service plan are revised and a copy of the revised UAI and notice of decision are mailed to the participant (and/or family or legal representative, as appropriate) and provider. Personal assistance agencies, certified family home providers, and assisted living providers are provided a revised plan by the nurse reviewer.

5. The participant (and/or family or legal representative, as appropriate) may initiate changes to the service plan. The participant (and/or family or legal representative, as appropriate) can contact the personal assistance agency to coordinate the service plan change. If the service plan change will result in a change in authorized services, the participant (and/or family or legal representative, as appropriate) may contact their agency to initiate a Change/Modification Request for the Department; or the participant (and/or family or legal representative, as appropriate) can directly contact their Medicaid nurse reviewer who will assist with updating the services and coordinating this information to the provider.

6. The Department ensures that the MCE will provide waiver services in accordance with the requirements in this approved waiver and in accordance with the requirements specified in the contract. The MCE will accept the Department's decision to approve or reject a service plan. The MCE will revise the service plan if the Department determines that a revision to a service plan is needed.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

☒ **Medicaid agency**

☐ **Operating agency**

☐ **Case manager**

☒ **Other**

Specify:

The Department will ensure that the MCE will maintain service plan forms for participants enrolled in the MMCP or Idaho Medicaid Plus.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a. The Department of Health & Welfare, Division of Medicaid, Bureau of Long Term Care staff are responsible for monitoring the implementation of the service plan and participant health and welfare. Additionally, the Department of Health & Welfare, Division of Medicaid, Bureau of Long Term Care staff will ensure that the MCE monitors the implementation of the service plan and participant health and welfare.

b. The following are the methods by which the Bureau of Long Term care monitors the implementation of the service plan and participant health and welfare, and follows up on issues identified during the monitoring processes.

1. During the annual reassessment, the nurse reviewer compares the services on the prior year's service plan against services billed.
2. During the annual reassessment the nurse reviewer completes a Nurse Reviewer Home Visit in the participants home, face-to-face, and checks for the following:
   a. Current service plan in the home
   b. Service plan includes all services identified in the previous assessment
   c. Service plan was updated as needed over the previous year
   d. Service plan is signed by the participant and provider
   e. Compares service plan to progress notes to determine if services provided in the amount/scope/duration identified in the assessment and on the service plan
   f. Participant (and/or family or legal representative as appropriate) is asked questions regarding their satisfaction with and input into the service plan
   g. Risk mitigation strategies to address HCB setting quality requirements and/or exceptions to HCB residential setting quality requirements, if present, have been documented appropriately in the service plan.

Data from the Nurse Reviewer Home Visit is sent to the provider for remediation when applicable. Regional Quality Improvement Specialists investigate if there are issues that require additional review. Nurse Reviewer Home Visit data is compiled quarterly for analysis. Individual provider performance is reviewed for identification of any trends and statewide quality improvement needs on service plans. Quality Improvement Specialists follow up with providers on corrective action plans to improve service plan development and implementation.

3. A quality assurance review is completed on providers every two years or more frequent if issues are identified in a complaint, or issues/trends are identified during the Nurse Reviewer Home Visit process. During the provider quality assurance reviews a statistically valid random sample of participant service plans are reviewed to determine if needs identified during the UAI are addressed on the service plan and delivered in accordance with the service plan.

4. As a condition of the provider agreement, providers must have a quality improvement plan in place. This plan must be approved by the Quality Improvement Specialist before a Medicaid provider agreement is issued and must address how the provider will monitor service plans.

c. Monitoring of service plans is conducted at the following frequencies:
1. Provider Quality Improvement (QI) Reviews - at least every two years
2. Nurse Reviewer Home Visits - annually at redetermination
3. Within 10 days of a complaint regarding the service plan
4. By the provider at the interval approved in their quality improvement plan

d. The Department will ensure that the MCE completes service plan implementation and monitoring consistent with waiver requirements. The MCE will continuously monitor the Individualized Care Plan and ensure any gaps in care are addressed in an integrated manner by the Interdisciplinary Care Team, including any necessary revisions to the Individualized Care Plan. The MCE will ensure that the Individualized Care Plan is updated on an ongoing basis as appointments occur, tests are completed, medications change, transitions made, goals are added or completed, etc.

e. The appropriateness of back-up plans and interventions, in addition to appropriate documentation of participant health and safety risks, is evaluated on an annual basis during the participant redetermination process and during biennial provider audits.

f. Access to non-waiver services is not evaluated as a component of monitoring waiver services. However, under Idaho Medicaid, A&D waiver participants have access to the Healthy Connections program for assistance with referrals and access to non-waiver services. In addition, Idaho recently implemented a Primary Care Medical Home model of tiered

reimbursement for certain primary care providers to encourage improved coordination of participant services.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of service plans reviewed that address participants' needs and health and safety risks as identified in the individual's assessment(s). a. Numerator: Number of service plans reviewed that document participants' needs and health and safety risk factors identified in the individual's assessment(s). b. Denominator: Number of plans reviewed in the representative sample.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%; Confidence Level = 95%
☒ **Other** Specify: MCE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

		Confidence Interval = +/- 5%; Confidence Level = 95%
☒ **Other** Specify: MCE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of service plans reviewed that addressed potential and real risks and had back up plan interventions in place. a. Numerator: Number of service plans reviewed that addressed potential and real risks and had back up plan interventions in place. b. Denominator: Number of service plans reviewed in the representative sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%; Confidence Level = 95%
☒ **Other** Specify: MCE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of service plans reviewed that address participants' personal goals. a. Numerator: Number of service plans reviewed that address participants' personal goals. b. Denominator: Number of service plans reviewed in the representative sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%; Confidence Level = 95%
☒ **Other**	☐ **Annually**	☐ **Stratified**

Specify: MCE		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of service plans that were revised when warranted by changes in participants' needs. a. Numerator: Number of service plans that were revised when warranted by changes in participants' needs. b. Denominator: Number of service plans reviewed that required revision as warranted by changes in participants' needs.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%; Confidence Level = 95%
☒ **Other** Specify: MCE	☐ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of service plans that were updated at least annually. Numerator: Number of service plans updated at least annually. Denominator: Number of service plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participant records reviewed that indicate services were delivered consistent with the service type, scope, amount, duration and frequency approved by the Department. a. Numerator: Number of records reviewed that indicate services were delivered consistent with approved service type, scope, amount, duration and frequency. b. Denominator: Number of records reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%; Confidence Level = 95%

☒ **Other** Specify: MCE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participant records reviewed that indicated participants were given a choice when selecting waiver service providers. a. Numerator: Number of participant records reviewed that indicated participants were given a choice when selecting waiver service providers. b. Denominator: Number of participant records reviewed in the representative sample.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%; Confidence Level = 95%
☒ **Other** Specify: MCE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of service plans reviewed that reflected participant choices (i.e., time of service, days of service, etc.) a. Numerator: Number of service plans reviewed that reflected participant choices. b. Denominator: Number of service plans reviewed.

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%; Confidence Level = 95%
☒ **Other**	☐ **Annually**	☐ **Stratified**

Specify: MCE		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Medicaid uses a variety of strategies to discover/identify problems/issues within the waiver program that are detailed below:

1. Internal File Audits: The Internal File Audit process is a review of participant records in the local Medicaid offices. The Nurse Manager (NM) audits a minimum of five waiver participant records each month. The results of the audits are entered into a data management tool and analyzed quarterly. The Internal File Audit monitors the following aspects of the service plan development and delivery.

a. Participants (and/or family or legal representative, as appropriate) are afforded a choice between waiver services and institutional care and offered a choice between/among waiver services and providers.

c. Services are cost effective.

d. The informed consent is completed and signed by the participant (and/or family or legal representative as appropriate).

2. Review and approval of certified family home (CFH) Negotiated Service Agreement: All service plans for services provided in a CFH are reviewed to assure they will meet the participant's needs and approved by the NR prior to authorization of services.

3. Nurse Reviewer Home Visit Process: Nurse Reviewers (NR) complete a NR home visit and conduct a review of the participant's service plan and interview with each participant on the A&D Waiver during the annual redetermination assessment. The results of the home visit are entered into a data management tool and analyzed quarterly. Results are also sent to the provider for immediate remediation if necessary. Provider corrective plans are requested when needed. The BLTC Quality Survey addresses the following aspects of service plan development and service delivery:

a. Service plans address participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

b. Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

c. Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.

d. Participant experience regarding aspects of the service plan development. For example, participants are asked if they had input into the days and times that they will receive services.

e. Service plan is signed by the participant (and/or family or legal representative as appropriate)

f. Service plan is signed by the provider.

g. If necessary, any mitigation strategies needed to ameliorate risk to the participant associated with the home and community-based setting requirements described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" and evidence of participant consent.

h. If necessary, any exception to the provider owned or residential HCBS qualities is documented appropriately and evidence of participant consent and Department approval is included with the participant's plan.

4. Provider Quality Assurance Reviews. The Medicaid Quality Improvement Specialist reviews each waiver provider per the provider qualification schedule in Appendix B. This review includes review of a random sample of participant records and monitors the following aspects of the service plan and service delivery:

a. Plan includes specific type, amount, frequency, & duration of services to be provided

b. Plan includes supports provided by family, friends, community, etc.

c. Plan includes participant goals

d. Plan promotes progress, prevention of regression/maintenance of skills, etc.

e. Plan includes providers of waiver services

5. Paid claims report: This report is retrieved by the NR and taken to the redetermination assessment. It is then compared to the progress notes by the NR to determine if services were provided (as evidenced by billed/paid claims).

6. MCE: The MCE is required to monitor service plan development to ensure compliance with waiver requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The State remediates individual problems as they are discovered via the following quality improvement strategies:
1. Internal File Audit: Nurse Manager and Program Manager (NM, PM) remediate any specific performance issues with the appropriate staff.

2. Nurse Reviewer Home Visit Report: A copy of the Quality Survey form with results is sent to the provider during the redetermination process. Individual provider data is also compiled and analyzed quarterly by the QI Specialist and provider corrective action plans are requested and monitored as needed.

3. Participant Experience Data: Participant experience data is collected as part of the Quality Survey. Any specific participant complaints/incidents are referred to the Complaint/Critical Incident Reporting process and are followed up by the NM or PM as appropriate.

4. The non-licensed/non-certified provider is responsible for the development and implementation of a quality assurance program which assures service delivery consistent with applicable rules. Results of individual quality assurance reviews conducted by IDHW shall be transmitted to the provider within 45 days of a review being completed. If deficiencies have been identified by the review, the provider agency shall submit to IDHW a corrective action plan for addressing the identified deficiencies. This corrective action plan shall be submitted to IDHW within 45 calendar days of receiving the results of a quality assurance review. Upon request, an agency shall also forward to IDHW the results of any implemented corrective action plan.

5. The IDHW Contract Monitor will issue a Monitoring Report to the MCE that identifies in writing the Performance Indicator(s) monitored, and that summarizes the preliminary results with the MCE. The MCE utilizes the same sampling methods as the IDHW for performance and quality improvement measures. Upon request by the MCE, the IDHW will meet with the MCE within ten (10) business days of their receipt of the Monitoring Report regarding the results. The MCE may dispute the findings via written appeal to the Contract Monitor within ten (10) business days of issuance of the report. The MCE must specifically address each disputed finding and justification for the appeal of the finding. The MCE is required to provide all documents necessary to dispute monitor results with its written appeal. The IDHW will render a final written decision on the appeal to the MCE within ten (10) business days of receipt of the MCE's dispute information, unless the parties agree in writing to extend the decision period.

If the MCE does not dispute the findings, the MCE shall have ten (10) business days from the date of the IDHW's monitoring report to cure the deficiencies found. If the MCE appeals the monitoring report, the MCE shall have ten (10) business days from the date of the IDHW's final written decision to cure the deficiencies. If the IDHW is not satisfied that the MCE has resolved the deficiencies, or made substantial progress toward resolution, the IDHW may assess the amounts listed in the Scope of Work as liquidated damages for each day the deficiency remains uncured.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

a. The nature of opportunities afforded to participants regarding participant direction of services:
The participants (and/or family or legal representative, as appropriate) may engage a fiscal intermediary (FI) agency as their provider or they may use a traditional agency model. There are several agencies throughout the state that provide A&D waiver services under the umbrella of a fiscal intermediary model. As a participant (and/or family or legal representative, as appropriate) choosing FI services, he/she has opportunities and takes responsibility for, and accepts potential risks and any resulting consequences for choices to manage certain waiver services which include, recruiting, selecting, managing, training, scheduling, dismissing, and arranging backup coverage. Specifically, the participant (and/or family or legal representative, as appropriate) may direct attendant care, homemaker, chore, companion, consultation and skilled nursing services.

b. How participants may take advantage of participant direction service opportunities:
At the time of assessment or reassessment, Nurse Reviewers discuss the findings of the assessment and the services that were indicated, as well as inform the participant (and/or family or legal representative, as appropriate) about the various options available. If participants are interested in the FI model, the Nurse Reviewer or MCE Care Coordinator provides information about the participant (and/or family or legal representative, as appropriate) responsibilities and their role in overseeing their care. Choosing a FI agency is an option under the Aged and Disabled Waiver. This option is designed for participants who desire more independence and responsibility for certain waiver services they receive. Specifically, the participant (and/or family or legal representative, as appropriate) may direct attendant care, homemaker, chore, companion, consultation and skilled nursing services. The participant can direct theses services themselves, or they can select a personal representative to direct services on their behalf. A personal assistant (PA) is someone who is hired to assist participants with activities they would do themselves if they were able. The PA's job duties are different depending on the participant's assessed needs. The personal assistant's job is to assist the participant with daily living activities. This includes but is not limited to, personal care, housekeeping, and participant health and safety.

c. The entities that support individuals who direct their services and the supports that they provide:
A Fiscal Intermediary is an agency that has responsibility for the following: directly assures compliance with legal requirements related to employment of waiver service providers; offers supportive services to enable participants or families of consumers to perform the required employer tasks themselves; bills the Medicaid program or the MCE, as appropriate, for services approved and authorized by the Department or the MCE; collects any participation in cost due; pays personal assistants and other waiver service providers for services; performs all necessary withholding as required by state and federal labor and tax laws, rules and regulations; assures that personal assistants providing services meet the standards and qualifications under IDAPA 16.03.329.; maintains liability insurance coverage; conducts, at least annually, participant satisfaction or quality control reviews that are available to the Department, the MCE, and the general public; offers a full range of services and performs all services contained in a written agreement between the participant (and/or family or legal representative, as appropriate) and the provider; and obtains such criminal background checks and health screens on new and existing employees of record and fact as required.

MMCP and Idaho Medicaid Plus Self-Direction of A&D Waiver Services and Personal Care Services:

The MCE will provide information, choice, and supports that include the availability of an individual to educate and assist the Enrollee in self-direction to promote self-direction of A&D Waiver services by Enrollees or their representative. The MCE will allow Enrollee self-direction of the following services through Personal Assistance Agencies (PAA) functioning as Fiscal Intermediary (FI) Agencies:
Companion Services,
Skilled Nursing,
Consultation,
Attendant Care,
Homemaker,
Chore Service, and
PCS.
The MCE will allow Enrollees to use FI services from providers that meet qualifications specified in the A&D Waiver located at: http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/AandDWaiver.pdf.
The MCE will pay for services rendered by a FI Agency functioning as an employer of record which includes payment for services, required taxes, and administrative activities for Enrollees who direct their own services.
FI Agencies must be enrolled as Medicaid providers to receive payment under this contract.
Provide the Enrollee with the option of having their A&D Waiver services provided by a PAA. Services provided by a PAA must be person-centered and the Enrollee must have a choice of the schedule for services and of who provides the

services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [ ] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- ( ) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- (●) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Participant (and/or family or legal representative, as appropriate) may direct attendant care, homemaker, chore, companion, consultation, skilled nursing services, and transition services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a. To inform decision-making concerning the election of participant direction:

Participants (and/or family or legal representative, as appropriate) are provided a variety of information from the Department of Health and Welfare to assist them in making the decision whether participant direction is for them. This documentation includes: Fiscal Intermediary (FI) Services Information Sheet, Agency Choice Form, Fiscal Intermediary - Participant Responsibilities Form that outlines respective responsibilities, Personal Assistant Training Log, Personal Assistant and FI Choice and Responsibilities. In addition, participants (and/or family or legal representatives, as appropriate) are given written information by the FI provider. This details what it means to self-direct (i.e. able and willing to make informed choices, ability to organize their environment), the responsibilities of self-direction (i.e. recruit, interview, hire, train, supervise, schedule and, if need be, dismiss the attendant of their choice, develop an implementation plan), and the responsibilities of self-direction with respect to grievances with their attendant (these are to be resolved by the participant (and/or family or legal representative, as appropriate). The Department will ensure that the MCE will provide information, choice, and supports that include the availability of an individual to educate and assist the participant in self-direction to promote self-direction of A&D Waiver services by participants or their representative.

b. The entity or entities responsible for furnishing Direction of Services information:

Participants (and/or family or legal representatives, as appropriate) are given written information by the FI provider. During the UAI assessment the nurse reviewer explains self direction and informs the participant (and/or family or legal representative, as appropriate) of their responsibilities, their role as employer, the process they must follow as far as signing the employee time sheet, maintaining progress notes, communicating with the provider agency, arranging and scheduling back-up, and training the attendant. The participant (and/or family or legal representative, as appropriate) is provided a list of qualified provider agencies. The participant (and/or family or legal representative, as appropriate) may contact the nurse reviewer as needed for assistance. The FI also provides information when a participant (and/or family or legal representative, as appropriate) first contacts them. The FI may also offer training and education concerning a participant's role and responsibilities. The Department will ensure that the MCE will provide information about the direction of services. The Department will also ensure that the MCE will make available an individual to educate and assist the participant in self-direction.

c. How when the Direction of Services information is provided on a timely basis:

Written and verbal information from the Nurse Reviewer is provided during the assessment or whenever requested. The FI provides the information when the participant (and/or family or legal representative, as appropriate) contacts them or whenever requested. Information on Self Directed Services is also posted on the Idaho Department of Health and Welfare website in the Medicaid, Home Care section.
http://www.healthandwelfare.idaho.gov/Medical/Medicaid/HomeCare/tabid/215/Default.aspx

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The state does not provide for the direction of waiver services by a representative.**
- ◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A legal representative or designee can assist a participant with self-direction if they are able to demonstrate that they are willing and able to support the participant fulfilling their responsibilities as a self-directing entity. The legal representative only assists the participant with directing services; they will not be providing companion, homemaker, chore, skilled nursing, consultation, or attendant care services.

If the participant requires a legal representative/designee, the representative will work with the nurse reviewer or the MCE registered nurse, the participant, and the FI agency representative to discuss minimum monitoring expectations by the representative. The typical monitoring expectation will be weekly to monthly. If more monitoring is required, documentation supporting the need is entered in the participant's file.

For a legal representative or designee to effectively complete their responsibilities, they must be able to provide impartial supervision and management of services. The nurse reviewer or RN Manager or MCE registered nurse may require the removal or exclusion of a legal representative or designee whenever an apparent or probable conflict-of-interest exists. Situations that constitute a conflict-of-interest include, but are not limited to when the legal representative or designee: is employed as the attendant; employs a member of their immediate family as the attendant; employs an attendant who is directly or indirectly able to exercise a significant fiscal/personal influence over them; employs an attendant over whom they are able to directly or indirectly exercise a significant fiscal/personal influence; who refuses to comply with the policies and procedures of the provider assistance agency with whom the participant has affiliated.

If the nurse reviewer discovers through the annual UAI reassessment; or, if the nurse review or MCE registered nurse discovers through a change/modification request, or agency staff or RN, that the participant's appointed representative is unable to fulfill the self direction role (ability to make informed choices, recruit, interview, hire, train, supervise employees), the nurse reviewer or MCE registered nurse will work with the FI agency to retrain the representative. If the representative is still unable to complete the self direction responsibilities, the participant (and/or family or legal representative, as appropriate) and agency will receive written notification. The notification will direct the participant or the guardian to select a different non-legal representative.

If the participant, guardian, or non-legal representative disagrees with the nurse reviewer decision, a meeting can be scheduled to discuss the decision. If the issue is not resolved, the parties may file a formal complaint with the Division of Medicaid or the MCE.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Skilled Nursing	☒	☐
Transition Services	☒	☐
Homemaker	☒	☐
Attendant Care	☒	☐
Consultation	☒	☐
Chore Service	☒	☐

Waiver Service	Employer Authority	Budget Authority
Companion Services	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Fiscal Intermediaries (FI) are used by those participants who wish to self-direct. The participant (and/or family or legal representative, as appropriate) chooses the FI when they want to self-direct as opposed to the traditional waiver agency provider. The FI provider advertises their services as such, and Department staff direct the participant (and/or family or legal representative, as appropriate) to these agencies if they chose to self-direct.

Prior to receiving approval to be a Medicaid Personal Assistance Agency - FI, the quality improvement specialist reviews the applicant's operating policies and procedures, criminal history clearances, liability and workers compensation policies, quality assurance process and procedures, and current licenses and certification for staff. The quality improvement specialist provides initial training for all new providers.

IDAPA 16.03.10.329.02 Each provider must have a signed provider agreement with the department for each of the services it provides. The A & D waiver provider agreement has additional terms that providers are expected to adhere to.

IDAPA 16.03.10.329.02 lists core tasks for Personal Assistance Agency that provides FI services.

The quality improvement specialist conducts FI agency reviews every two years, or more frequently if concerns arise.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The administrative functions are part of the service they provide to self-directing participants. They are not reimbursed by Medicaid beyond the regular Medicaid reimbursement. The Department ensures that the MCE reimburses all providers at rates no less than the current Medicaid provider rates.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

Fiscal Intermediaries provide education to the participant (and/or family or legal representative, as appropriate) about interviewing, hiring, firing and the components of self-direction.

Criminal history checks are done in accordance with Idaho Administrative Code at IDAPA 16.05.03.100 & 170 "Rules Governing Mandatory Criminal History Checks". Staff of personal assistance agencies acting as fiscal intermediaries are required to have criminal history background checks.

The FI agency is responsible for verifying staff qualifications and obtaining criminal history background clearances.

Supports furnished when the participant exercises budget authority:

- [ ] **Maintain a separate account for each participant's participant-directed budget**
- [ ] **Track and report participant funds, disbursements and the balance of participant funds**
- [ ] **Process and pay invoices for goods and services approved in the service plan**
- [ ] **Provide participant with periodic reports of expenditures and the status of the participant-directed**

budget

☐ **Other services and supports**

Specify:

Additional functions/activities:

☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☐ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

a. Monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform:

Quality improvement reviews are conducted by the Quality Improvement Specialist. These reviews include employee records to ensure compliance with provider qualifications and applicable rules, matching time sheets to reviewing hours billed. In addition, during annual redetermination of services or complaint investigations, the Nurse Reviewer reviews the daily care worksheets in the participant's home. The services documented on the worksheet are compared to the current Uniform Assessment Instrument Service Plan to ensure identified services are being provided.

b. The entity (or entities) responsible for monitoring FMS oversight:

Bureau of Long Term Care is responsible for the monitoring. The Department ensures that FI Agencies must be enrolled as Medicaid providers to receive payment under the Department’s contract with the MCE.

c. How frequently is performance assessed for oversight of FMS entities:

Quality improvement reviews are completed on each agency every two years, or more frequently if concerns arise.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the

payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☐ **Waiver Service Coverage.**
Information and assistance in support of
participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Supported Employment	☐
Skilled Nursing	☐
Personal Emergency Response System	☐
Transition Services	☐
Residential Habilitation	☐
Respite	☐
Homemaker	☐
Environmental Accessibility Adaptations	☐
Attendant Care	☐
Specialized Medical Equipment and Supplies	☐
Consultation	☐
Home Delivered Meals	☐
Day Habilitation	☐
Non-medical Transportation	☐
Chore Service	☐
Adult Day Health	☐
Companion Services	☐
Adult Residential Care	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the

methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

a. Types of entities that furnish Participant Direction Services:

Information and assistance in support of participant direction are furnished as an administrative activity by Fiscal Intermediary Agencies, Medicaid staff, and MCE staff. Information on Direction of Services is also posted on the Idaho Department of Health and Welfare website on the Medicaid, Home Care link.

b. How Participant Direction Services are procured and compensated:

1) The Fiscal Intermediary agency that provides services for the participant (and/or family or legal representative, as appropriate) procures and compensates these supports.
2) The Fiscal Intermediary offers training and education as an ongoing service to any participant (and/or family or legal representative, as appropriate) who requests it.
3) This service is not compensated separately.

c. Describe in detail the supports that are furnished for each participant direction opportunity under the waiver:

1)The supports offered by Nurse Reviewers, the MCE registered nurse, or MCE Care Coordinator/Care Specialist are of an informational nature. They explain to the participant (and/or family or legal representative, as appropriate) their responsibilities, their role as employer, the process they must follow as far as signing the employee time sheet, maintaining progress notes, communicating with the provider agency, arranging and scheduling back-up, and training the attendant.
2) The training and support offered by the Fiscal Intermediary includes: formal training on hiring and interviewing; training on Department rules or MCE rules of qualifications of attendants; training on how to train and direct the attendant; education on firing an attendant; training on mediating disputes with an attendant.
3)During the annual redetermination of services and complaint investigations, the Nurse Reviewers review the daily care worksheets in the participant's home. The services documented on the worksheet are compared to the current Uniform Assessment Instrument and Service Plan to ensure identified services are being provided.
4) The Quality Improvement staff review the participant records during their quality improvement reviews.

d. The methods and frequency of assessing the performance of the entities that furnish Participant Direction Services:

Quality Improvement Specialists conduct a Provider Quality Review of Fiscal Intermediary Agencies every 2 years, or more often if concerns arise.

e. The entity or entities responsible for assessing performance:

The Department of Health and Welfare, Division of Medicaid is responsible for assessing performance.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

If a participant (and/or family or legal representative, as appropriate) voluntarily terminates self-direction, they or the Fiscal Intermediary must notify the Department or the MCE. The Nurse Reviewer, MCE registered nurse, or MCE Care Coordinator/Care Specialist contacts the participant (and/or family or legal representative, as appropriate) and asks them to select another provider. If indicated, the Nurse Reviewer will conduct a new assessment using the Uniform Assessment Instrument if the participant (and/or family or legal representative, as appropriate) or FI reports a change in functioning that is significant enough to warrant a change in the amount of required services. A new Service Plan is developed with input from the participant (and/or family or legal representative, as appropriate). The participant(and/or family or legal representative, as appropriate) is offered the opportunity to select a new provider. The Nurse Reviewer or MCE registered nurse will send the Uniform Assessment Instrument and Support Plan to the new provider. This information is sent to the selected provider along with authorization for services. The Nurse Reviewer, MCE registered nurse, or Care Coordinator/Care Specialist communicates with the new agency about the change from self-direction and ensures services will be provided immediately if necessary, and verified with a completed and signed Acknowledgment of Service Delivery. A Service Plan will be completed by the new provider agency with participant (and/or family or legal representative, as appropriate) input. The new provider agency will be authorized to provide services immediately if appropriate.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The State or the MCE may terminate use of participant direction in the following circumstances:

1. The participant does not have available a complete or appropriate implementation plan or progress notes after the opportunity to correct has passed;
2. The participant has demonstrated through a danger to health or safety, an inability to self-direct;
3. The participant violates a policy or procedure of the fiscal intermediary agency and does not correct after warning.

The above issues may be identified by the nurse reviewer home visit or by a MCE Care Coordinator/Care Specialist home visit, complaint investigation, quality improvement visit, or FI reporting to the Department or the MCE. The participant (and/or family or legal representative, as appropriate) will be sent a letter within fourteen (14) days of the nurse reviewer or MCE Care Coordinator/Care Specialist's identification of the above issues.

To assure participant health and welfare is assured during the transition, the participant (and/or family or legal representative, as appropriate) will have fifteen (15) days to select a provider-managed service to assume all employer related duties. The nurse reviewer, MCE registered nurse, or MCE Care Coordinator/Care Specialist will verify that a participant (and/or family or legal representative, as appropriate) has selected a personal assistance agency through receipt of a signed Acknowledgment of Service Delivery Communication form. The nurse reviewer, MCE registered nurse, or MCE Care Coordinator/Care Specialist will also verify that there will not be a lapse in services so that the health and welfare of the participant is assured.

In the event that participant direction is involuntarily terminated, the participant will receive a Notice of Decision generated from the Idaho MMIS, indicating that the participant has been transitioned to a non-self-directed agency for service provision. All notices of decision include appeal rights with instructions on how to request a Fair Hearing and the required timeframes for doing so.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	467	
Year 2	491	
Year 3	515	
Year 4	541	
Year 5	568	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports

are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Fiscal Intermediary Agencies

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

The state's method does not vary from Appendix C-2-a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☐ **Determine the amount paid for services within the state's established limits**
- ☐ **Substitute service providers**
- ☐ **Schedule the provision of services**
- ☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☐ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to

offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Applicants and participants (and/or family or legal representative, as appropriate) are notified of the opportunity to request a fair hearing each time a decision is made regarding the approval, denial, reduction, or increase in services or program eligibility. When an applicant or participant is authorized for services, the services are entered into the MMIS database and a Notice of Decision is generated and mailed to the participant. On the back of this notice is the participant's appeal instructions.

The applicant/participant (and/or family or legal representative, as appropriate) or his representative has 28 days from date the Notice of Decision was mailed by the Department to request a hearing in writing.

Appeals must be filed in writing and state the appellant's name, address, phone number, and the remedy requested. Appeals should be accompanied by a copy of the Notice of Decision that is the subject of the appeal. The appellant may send the request for a hearing to the Hearing Coordinator, Department of Health & Welfare Administrative Procedures Section or to Medicaid. Medicaid staff will forward the request to the Hearing Coordinator. An appeal is filed when it is received by the Department or postmarked within the time limits. The appellant may request a Fair Hearing Request Form from Medicaid staff if they wish to continue receiving benefits until a decision has been made by the hearing officer. If the participant (and/or family or legal representative, as appropriate) has questions and needs further assistance, the Medicaid staff will refer them to Idaho Legal Aid, one of the State's Ombudsmen, Disability Rights Idaho and/or AAA (Area Agency on Aging).

The applicant/participant (and/or family or legal representative, as appropriate) may contact a department employee to assist with requesting a fair hearing. A guardian or power of attorney for medical care may submit a written hearing request to the State. The attendant, family, or natural support(s) may submit a written hearing request to the State on behalf of the participant. The nurse reviewer would contact the participant (and/or family or legal representative, as appropriate) by phone to verify the participant is requesting a fair hearing.

Applicant/participant (and/or family or legal representative, as appropriate) has the right to request a pre-hearing conference. This conference may be used to informally identify or resolve the issue or to provide information to the Department or applicant. The conference does not affect the applicant's/participant's right to a hearing. After the conference, a hearing is held unless applicant withdraws the request, or department withdraws the action the applicant is contesting.

All fair hearing requests are submitted to the State's Administrative Procedures Section, where the request is logged and forwarded to the Division of Medicaid. The Medicaid Appeals Coordinator tracks the hearing requests.

Aged & Disabled waiver participants (and/or family or legal representative, as appropriate) will be notified by the Department when waiver services are terminated, reduced, or when the participant fails to meet level of care but remains eligible for other services, such as state plan. The Department will mail the participant (and/or family or legal representative, as appropriate) a MMIS generated Notice of Decision with Appeal Rights.

Requirements for MCE:

Participants enrolled in the MCCP or Idaho Medicaid Plus must exhaust the MCE grievance and appeals process before accessing the Department fair hearing process.

The MCE must comply with its contract with the Department regarding all aspects of the appeals system. The Department will ensure that the MCE implements and maintains a system for participants that includes an appeals system and access to the Department's fair hearing system that complies with 42 CFR §438.400-424, and allows any participant the opportunity to challenge the MCE's action(s) related to any covered service. The MCE's Notice of Action must explain that the rules governing the state's fair hearing system, which is available to a participant who exhausts appeal rights with the MCE.

For Appeals not resolved in favor of the participant, the MCE's disposition notice must include, in addition to the information specified in all disposition notices:
(1) The right to request a State fair hearing and instruction on how to do so;
(2) The right to request to receive benefits while the hearing is pending, and instruction on how to make the request; and
(3) Notice that the participant will be held liable for the cost of those benefits if the State fair hearing decision upholds the MCE's action.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Idaho Division of Medicaid

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The BLTC has streamlined its Complaint/Critical Incident system in order to facilitate data collection, analysis of trends, and resolution of problems that arise with the administration of the waiver program and delivery of waiver services. The new Complaint System encompasses the grievance/complaint process and the critical event or incident reporting process. The updated system is based around a continuum of potential issues that can be analyzed based on category rather than relying on a distinction between a complaint and critical incidents. Any complaint may rise to the level of a critical issue based on its severity, and will be addressed accordingly by the BLTC. Below are the complaint categories within the Complaint System:

ABUSE: The intentional or negligent infliction of physical pain, injury or mental injury. Idaho Statute Title 39-5302(1)

ACCESS: Issues involving the availability of services; barriers to obtaining services; or lack of resources/services.

BENEFIT AMOUNT: A disagreement by a participant regarding the amount of benefits that they received. Appeal rights must always be discussed with the participant in a benefit amount investigation.

CONFIDENTIALITY: Not talking about or disclosing personal information regarding a participant except to appropriate parties, with the participant's permission.

PRIVACY: Issues dealing with the rights of participants to access and control their health information and not have it used or disclosed by others against their wishes.

DISCRIMINATION: The prejudicial treatment of individuals protected under federal and/or state law (includes any form of discrimination based on race, color, sex, national origin, age, religion, or disability).

EXPLOITATION: An action which may include, but is not limited to, the misuse of a vulnerable adult's funds, property, or resources by another person for profit or advantage.
Idaho Statute Title 39-5302(7)

FRAUD: An intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. IDAPA 16.03.09.201.05

HOSPITALIZATION (INCIDENT RELATED): When a participant is hospitalized as a direct result of an incident by a paid provider, (medication error, physical injury, quality of care, neglect, treatment omission, or failure to follow established plans of care).

IMPROPER BILLING PRACTICES: Issue where provider billed in error or without sufficient documentation (not intentional).

INJURY CAUSED BY RESTRAINTS: An injury to a participant is caused by any of the following restraints:
o Physical restraint - Any manual method or physical or manual device, material or equipment attached or adjacent to the participant's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.
o Chemical restraint - Any drug that is used for discipline or convenience and not required to treat medical symptoms; and/or used to involuntarily restrict the movement or function of an individual.
o Mechanical Restraint - Any device used to control acute or episodic behavior and involuntarily restricts the movement or function of an individual or a portion of an individual's body.

MEDICATION ERROR: Any type of medication-related mistake that may negatively impact a participant's health or cause him/her serious injury.

NEGLECT: Failure of a caretaker to provide food, clothing, shelter, or medical care reasonably necessary to sustain life and health of a vulnerable adult or child, or the failure of a vulnerable adult to provide those services to him/herself.
Idaho Statute Title 39-5302(8)

MISSING PARTICIPANT: A participant's whereabouts is unknown, whatever the circumstances of the disappearance.

PARTICIPANT IS THE VICTIM OF A CRIME: A participant who suffers harm as a direct result of an act committed,

or allegedly committed, by another person in the course of a criminal offense. “Harm” means the participant suffered actual physical harm, mental injury, or the participant’s property was deliberately taken, destroyed, or damaged.

QUALITY OF CARE: Issues that involve the meeting or not meeting of rules, policies, or commonly accepted practice standards around care/services provided to participants of the Department.

SAFETY: The participant is placed in a position of danger and risk, either intentionally or unintentionally.

SERIOUS INJURY: An injury that occurs while under the care of a provider or as a result of a provider action that requires professional medical treatment (e.g. fractures, wounds requiring stitches).

SUSPICIOUS DEATH: A death is labeled as suspicious when either a crime is involved, accident has occurred, the death is not from an expected medical prognosis, a participant dies unexpectedly under care, or when a participant’s death occurs because of trauma in a medical setting.

VIOLATION OF RIGHTS: An intentional or unintentional infringement or transgression against a participant’s rights as an individual or under the Medicaid program. Rights violations include, but are not limited to:
- The Right to be treated with dignity and respect.
- The Right to a choice of providers/caregivers/when services are provided.
- The Right to receive services in a setting that meets Home and Community-Based Services requirements.

OTHER: When the Complaint does not fit one of the classifications listed, this classification may be used, and must describe the Complaint.

COMPLAINTS ARE NOT:
Program inquiries.
Requests for information.
Complaints beyond the jurisdiction of the Department that are referred immediately to the appropriate agency.
Legal actions other than appeals.
Employee specific issues – employee-specific Complaints are routed to the appropriate supervisor or to program management.
Referrals.

RESPONSE TIME FRAMES FOR COMPLAINTS:

Complaints require a timely response. Guidelines for response times for a Complaint are based on two priority levels:

Priority one: There is an immediate health or safety issue. Idaho Code requires that complaints or reports of abuse, neglect, or exploitation must be reported immediately to Adult/Child Protection and to the appropriate law enforcement agency within 4 hours. A report of any other Complaint that may impact the health and/or safety of a participant must be responded to as appropriate to assure the health and safety of the participant. Priority one Complaints may result in an interim resolution/response until a permanent resolution/response can be accomplished.

Priority two: There is not an immediate health or safety issue. Follow BLTC Standards for response times on phone calls, letters, etc.

Note – At any time in the process of receiving and addressing a Complaint, the Director, Administrator, or Bureau Chief may assign higher priority levels that those defined above.

PROCESS FOR ADDRESSING COMPLAINTS

1. A Complaint may be received by phone, letter, in person, fax, email, or during a redetermination assessment.
2. A Complaint requires a documented response to the person submitting the Complaint. The mode and content of the reply depends on the nature or complexity of the Complaint.
3. Documentation Policy: The following documentation, when applicable, is attached to the Complaint within the

Complaint Tracking Tool database:
-Copy of the original written complaint
-Copy of any pertinent letters
-Copy of the written response to the incident
-Narrative. Narratives should be brief, concise, accurate, non-judgmental, and professional. Narratives must include the date the entry is made and initials of staff making the entry.
4. Steps the Department Takes:
A) Validate understanding of the Complaint when received.
B) Access the Complaint Tracking Tool site, and search the database to determine whether this is a new Complaint, or if it is an open case. If it is an open case, enter the update in the Notes field and notify (by e-mail) the individual currently working on the Complaint of the contact. Scan and attach any new information, if applicable, or send any new information to the individual working on the Complaint.
C) If it is a new Complaint, enter the details into the database, including the submitter name, address, phone number, date received, nature of complaint, and Priority Level.
D) If all parties agree that a resolution can be made at the initial point of contact, finalize the entry, complete follow up procedures and close complaint.
E) If a resolution cannot be made at this initial point of contact, then determine which program or Region the Complaint belongs to.
F) Refer the Complaint to the appropriate supervisor/manager. The supervisor/manager assigns the Complaint to appropriate program staff, whose name is entered into the report.
G) Complete the investigation within the allowed time period, to include making timely reports to external agencies as required by statute and policy.
H) When drafting a Complaint response, ensure that it is approved by supervisor/manager prior to distribution.
I) If the assignee cannot meet the due date, a request for an extension must be made to the assignee program supervisor or manager.
J) Once the Complaint has been resolved, enter the resolution/response date and narrative.

Upon resolving the Complaint, the assigned staff person will complete all documentation, notify appropriate agencies and participants, and notify the Program Manager of the results and findings. Additionally, when corrective actions are required, the Program Manager will notify BLTCC of investigation findings and recommended resolution. The BLTCC may require that the investigating staff person or Unit expand the investigation or take additional action.

QUALITY ASSURANCE FOR COMPLAINTS:
- Participants are advised of where and how to file complaints of suspected abuse, neglect, or exploitation during the assessment process. Participants are given a brochure that summarizes what participants need to know about long-term care services and supports.
- Participants are advised of where they can get help with reporting child or elder abuse/neglect/exploitation or where to report Medicaid fraud on the Department of Health and Welfare Web site at:
http://healthandwelfare.idaho.gov/Medical/tabid/61/Default.aspx
- All Complaints will be entered and tracked in the Complaint Tracking Tool. Managers and Supervisors are accountable to assure that staff use the database.
- Complaints will be processed in a timely manner
- Managers and Supervisors review reports and take appropriate actions
- Narrative entries into the application will meet Department standards on appropriate communication
- Managers and Supervisors or Program QI staff are accountable to assure that application narratives meet standards
- All written response/resolutions will be reviewed for compliance with Program requirements
- All written communication will be reviewed by the program designee(s) prior to mailing
- Managers/Supervisors or Program QI staff are responsible for assuring that responses are reviewed

QUALITY IMPROVEMENT FOR COMPLAINTS:
- Meet Department and Division goals in responding to Complaints in a consistent, timely and understandable manner
- Collect baseline and ongoing data for quality assurance standards by which to measure program compliance with the standards
- Review reports and take corrective actions if needed on the timeliness of complaint responses/resolution, quality of narratives, quality of responses, and numbers and types of Complaints

State law related to this topic:

Idaho Code Title 39, Health and Safety Chapter 53; Adult Abuse, Neglect And Exploitation Act

The Department will ensure the MCE maintains policies and procedures for resolving and tracking Complaints consistent with the requirements listed above and the Scope of Work.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The BLTC has streamlined its Complaint/Critical Incident system in order to facilitate data collection, analysis of trends, and resolution of problems that arise with the administration of the waiver program, and delivery of waiver services. The new Complaint System encompasses the grievance/complaint process and the critical event or incident reporting process. The updated system is based around a continuum of potential issues that can be analyzed based on category rather than relying on a distinction between a complaint and critical incident. Any complaint may rise to the level of a critical issue based on its severity, and will be addressed accordingly by the BLTC. Below are the complaint categories within the Complaint System:

ABUSE: The intentional or negligent infliction of physical pain, injury, or mental injury. Idaho Statute Title 39-5302(1)

ACCESS: Issues involving the availability of services; barriers to obtaining services; or lack of resources/services.

BENEFIT AMOUNT: A disagreement by a participant regarding the amount of benefits that they received. Appeal rights must always be discussed with the participant in a benefit amount investigation.

CONFIDENTIALITY: Not talking about or disclosing personal information regarding a participant except to appropriate parties, with the participant's permission.

PRIVACY: Issues dealing with the rights of participants to access and control their health information and not have it used or disclosed by others against their wishes.

DISCRIMINATION: The prejudicial treatment of individuals protected under federal and/or state law (includes any form of discrimination based on race, color, sex, national origin, age, religion, or disability).

EXPLOITATION: An action which may include, but is not limited to, the misuse of a vulnerable adult's funds, property, or resources by another person for profit or advantage.
Idaho Statute Title 39-5302(7)

FRAUD: An intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. IDAPA 16.03.09.201.05

HOSPITALIZATION (INCIDENT RELATED): When a participant is hospitalized as a direct result of an incident by a paid provider, (medication error, physical injury, quality of care, neglect, treatment omission, or failure to follow established plans of care).

IMPROPER BILLING PRACTICES: Issue where provider billed in error or without sufficient documentation (not intentional).

INJURY CAUSED BY RESTRAINTS: An injury to a participant is caused by any of the following restraints:
o Physical restraint - Any manual method or physical or manual device, material, or equipment attached or adjacent to the participant's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.
o Chemical restraint - Any drug that is used for discipline or convenience and not required to treat medical symptoms; and/or used to involuntarily restrict the movement or function of an individual.
o Mechanical Restraint - Any device used to control acute or episodic behavior, and involuntarily restricts the movement or function of an individual or a portion of an individual's body.

MEDICATION ERROR: Any type of medication-related mistake that may negatively impact a participant's health or cause him/her serious injury.

NEGLECT: Failure of a caretaker to provide food, clothing, shelter, or medical care reasonably necessary to sustain life and health of a vulnerable adult or child, or the failure of a vulnerable adult to provide those services to him/herself.
Idaho Statute Title 39-5302(8)

MISSING PARTICIPANT: A participant's whereabouts is unknown, whatever the circumstances of the disappearance.

PARTICIPANT IS THE VICTIM OF A CRIME: A participant who suffers harm as a direct result of an act committed,

or allegedly committed, by another person in the course of a criminal offense. “Harm” means the participant suffered actual physical harm, mental injury, or the participant’s property was deliberately taken, destroyed, or damaged.

QUALITY OF CARE: Issues that involve the meeting or not meeting of rules, policies or commonly accepted practice standards around care/services provided to participants of the Department.

SAFETY: The participant is placed in a position of danger and risk, either intentionally or unintentionally.

SERIOUS INJURY: An injury that occurs while under the care of a provider or as a result of a provider action that requires professional medical treatment (e.g. fractures, wounds requiring stitches).

SUSPICIOUS DEATH: A death is labeled as suspicious when either a crime is involved, accident has occurred, the death is not from an expected medical prognosis, a participant dies unexpectedly under care, or when a participant’s death occurs because of trauma in a medical setting.

VIOLATION OF RIGHTS: An intentional or unintentional infringement or transgression against a participant’s rights as an individual or under the Medicaid program. Rights violations include, but are not limited to:
- The Right to be treated with dignity and respect.
- The Right to a choice of providers/caregivers/when services are provided.
- The Right to receive services in a setting that meets Home and Community-Based Services requirements.

OTHER: When the Complaint does not fit under one of the classifications listed, this classification may be used, and must describe the Complaint.

The following are the individuals/entities that are required to report incidents of abuse, neglect, and exploitation:
- All Department of Health & Welfare staff are mandatory reporters
- All providers with a signed Medicaid provider agreement are mandatory reporters

Duty to Report is included in Idaho Code, Title 39, Health and Safety Chapter 53; Adult Abuse, Neglect and Exploitation Act

RESPONSE TIME FRAMES FOR COMPLAINTS:

Complaints require a timely response. Guidelines for response times for a Complaint are based on two priority levels:

Priority one: There is an immediate health or safety issue. Idaho code requires that complaints or reports of abuse, neglect, or exploitation must be reported immediately to Adult/Child Protection and to the appropriate law enforcement agency within 4 hours. A report of any other Complaint that may impact the health and/or safety of a participant must be responded to as appropriate to assure the health and safety of the participant. Priority one Complaints may result in an interim resolution until a permanent resolution can be accomplished.

Priority two: There is not an immediate health or safety issue. Follow BLTC Standards for response times on phone calls, letters, etc.

Note – At any time in the process of receiving and addressing a Complaint, the Director, Administrator, or Bureau Chief may assign higher priority levels that those defined above.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Training and/or information on protection from abuse, neglect, and exploitation for participants (and/or family or legal representative as appropriate) and how to report to appropriate authorities or entities is provided through the following:

- Upon enrollment as an A & D Waiver Provider, the Quality Improvement Specialist provides training which includes definitions of Adult Abuse, Neglect, Exploitation, Abandonment, and Neglect and also covers Idaho Statute on Duty to Report.
- Participants are given information regarding the waiver during the assessment process. In that information they are informed that the agency they choose should give them information on where and how to report incidents of abuse, neglect, or exploitation to the agency.
- On the Medicaid Home Page, a link is provided to the public with information on "I want help with Reporting Elder Abuse/Neglect".
- A brochure that summarizes what participants need to know about long-term care services and supports is provided to and discussed with each A & D participant. The brochure includes education regarding neglect, abuse, and exploitation, along with a place to put the local Adult Protection telephone number.
- A pocket guide on "Warning Signs of Elder Abuse" and Idaho Statutes on Duty to Report and Vulnerable Adults were distributed to and discussed with all Nurses statewide in the Idaho A & D Waiver Program.
- Bureau of Long Term Care in the state of Idaho is an active member of the Justice Alliance for Vulnerable Adults.
- DisAbility Rights Idaho is a protection and advocacy agency for individuals with disabilities that provides public policy and advocacy rights through information, education, and individual assistance to address abuse and neglect.
- State Independent Living Council of Idaho provides legislative and advocacy efforts regarding abuse toward individuals with disabilities.
- The Idaho Commission on Aging, Idaho's adult protection agency, provides adult protection services to safeguard vulnerable adults through investigations of reports alleging abuse, neglect, self-neglect, or exploitation, and arrangements for the provision of emergency or supportive services necessary to reduce or eliminate risk of harm. The Idaho Commission on Aging offers information for participants and the public on reporting abuse, neglect, and exploitation at http://aging.idaho.gov/protection/elder.html.
- The MCE must advise participants of where they can get help with reporting elder abuse/neglect/exploitation, or where to report Medicaid fraud on the IDHW website at: http://healthandwelfare.idaho.gov/Medical/tabid/61/Default.aspx.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Bureau of Long Term Care in the Division of Medicaid responds to all Complaints, including Complaints that rise to the level of a critical issue. Reports are investigated and/or referred to the appropriate entity and tracked in the Complaint Tracking Tool.

PROCESS FOR ADDRESSING COMPLAINTS

1. A Complaint may be received by phone, letter, in person, fax, email, or during a redetermination assessment.
2. A Complaint requires a documented response to the person submitting the Complaint. The mode and content of the reply depends on the nature or complexity of the Complaint.
3. Documentation Policy: The following documentation, when applicable, is attached to the Complaint within the Complaint Tracking Tool database:
- Copy of the original written complaint
- Copy of any pertinent letters
- Copy of the written response to the incident
- Narrative. Narratives should be brief, concise, accurate, non-judgmental, and professional. Narratives must include the date the entry is made and initials of staff making the entry.
4. Steps the Department Takes:
A) Validate understanding of the Complaint when received.
B) Access the Complaint Tracking Tool site and search the database to determine whether this is a new Complaint, or if it is an open case. If it is an open case, enter the update in the Notes field and notify (by e-mail) the individual currently working on the Complaint of the contact. Scan and attach any new information, if applicable, or send any new information to the individual working on the Complaint.
C) If it is a new Complaint, enter the details into the database, including the submitter name, address, phone number, date received, nature of complaint, and Priority Level.
D) If all parties agree that a resolution can be made at the initial point of contact, finalize the entry, complete follow up procedures, and close complaint.
E) If a resolution cannot be made at this initial point of contact, then determine which program or Region the Complaint belongs to.
F) Refer the Complaint to the appropriate supervisor/manager. The Supervisor/Manager assigns the Complaint to appropriate program staff, whose name is entered into the report.
G) Complete the investigation within the allowed time period to include making timely reports to external agencies as required by statute and policy.
H) When drafting a Complaint response, ensure that it is approved by a supervisor/manager prior to distribution.
I) If the assignee cannot meet the due date, a request for an extension must be made to the assignee program supervisor or manager.
J) Once the Complaint has been resolved, enter the resolution/response date and narrative.

Upon resolving the Complaint, the assigned staff person will complete all documentation, notify appropriate agencies and participants, and notify the Program Manager of the results and findings. Additionally, when corrective actions are required, the Program Manager will notify BLTCC of investigation findings and recommended resolution. The BLTCC may require that the investigating staff person or Unit expand the investigation or take additional action.

RESPONSE TIME FRAMES FOR COMPLAINTS:

Complaints require a timely response. Guidelines for response times for a Complaint are based on two priority levels:

Priority one: There is an immediate health or safety issue. Idaho Code requires that complaints or reports of abuse, neglect, or exploitation must be reported immediately to Adult/Child Protection and to the appropriate law enforcement agency within 4 hours. A report of any other Complaint that may impact the health and/or safety of a participant must be responded to as appropriate to assure the health and safety of the participant. Priority one Complaints may result in an interim resolution/response until a permanent resolution/response can be accomplished.

Priority two: There is not an immediate health or safety issue. Follow BLTC Standards for response times on phone calls, letters, etc.

Note – At any time in the process of receiving and addressing a Complaint, the Director, Administrator, or Bureau Chief may assign higher priority levels that those defined above.

The Bureau of Long Term Care Committee (BLTCC) is responsible for ensuring that staff adhere to these timelines. Review of statewide compliance with priority timelines is assessed at least quarterly during the BLTCC meetings. The BLTCC consists of the Bureau Chief, the Regional Program Managers, and Central Office policy staff.

REPORTS OF ABUSE, NEGLECT, OR EXPLOITATION REFERRED TO ADULT PROTECTION

Reports of events that come to the Department directly regarding abuse, neglect, or exploitation are investigated and/or referred to the local adult protection agency (Idaho Commission on Aging) for further investigation. The Idaho Commission on Aging has the responsibility in Idaho Code to investigate allegations of abuse, neglect, or exploitation involving a vulnerable adult, and to make appropriate referrals to law enforcement. If the allegations in the report indicate that an emergency exists, the commission or contractor must initiate an investigation immediately, and initiate contact with the alleged vulnerable adult within twenty-four (24) hours from the time the report is received. All other investigations must be initiated within seventy-two (72) hours from the time the report is received. Investigations include a determination of the nature, extent, and cause of the abuse, neglect, or exploitation, examination of evidence, and consultation with persons thought to have knowledge of the circumstances and identification, if possible, of the person alleged to be responsible for the abuse, neglect or exploitation of the vulnerable adult. At the conclusion of the investigation, the adult protection worker determinations that the allegation is either substantiated or unsubstantiated.

Substantiated: A report of abuse, neglect, and/or exploitation of a vulnerable adult by another individual is deemed substantiated when, based upon limited investigation and review, the AP worker perceives the report to be credible. A substantiated report shall be referred immediately to law enforcement for further investigation and action. Additionally, the name of an individual against whom a substantiated report was filed shall be forwarded to the Department for further investigation. In substantiated cases of self-neglect, the adult protection worker shall initiate appropriate referrals for supportive services with the consent of the vulnerable adult or his legal representative.

Unsubstantiated: The adult protection worker shall close the file if a report of abuse, neglect, and/or exploitation by another individual of a vulnerable adult is not substantiated. If a report is not substantiated, but the AP worker determines that the vulnerable adult has unmet service needs, the adult protection worker shall initiate appropriate referrals for supportive services with consent of the vulnerable adult or his legal representative.

COMPLAINTS RECEIVED BY THE MCE

The Department will ensure that the MCE implements and maintains policies and procedures for resolving and tracking Complaints, including those that rise to critical issues based on severity. The MCE must meet the following requirements:
1. The MCE and its network providers shall abide by Idaho State law including those laws regarding mandatory reporting.
2. Complaints may be lodged by a participant, participant's authorized representative, or a provider either orally or in writing.
3. The MCE must designate a person to conduct a reasonable investigation or inquiry into allegations made by or on behalf of a participant or provider that shall give due consideration and deliberation to all information and arguments submitted by or on behalf of the participant or provider.
4. The MCE or its designee shall resolve each Complaint by documenting at a minimum:
(1) A summary of the general complaint, including a statement of the issues raised and pertinent facts determined by the investigation;
(2) A statement of the specific coverage or policy or procedure provisions that apply; and
(3) A decision or resolution of the Complaint including a reasoned statement explaining the basis for the decision or resolution.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Bureau of Long Term Care in the Division of Medicaid is responsible for overseeing the reporting and response to complaints, including those that rise to the level of a critical issue. This oversight is conducted by the following processes:

1. All complaints are entered into the Complaint Tracking Tool.

2. All Bureau of Long Term Care staff are trained (including periodic refresher training) on the categories of Complaints, their roles in reporting, and, if applicable, investigation of Complaints.

3. Bureau of Long Term Care Program Managers review all Complaints entered into the Complaint Tracking Tool on a quarterly basis to monitor the quality of the data entry, appropriateness of resolution, and timeliness of investigations. Individual staff remediation is identified, and training provided when needed, and system improvements are identified and implemented on an ongoing basis as needed.

4. During provider quality reviews, the QI specialist reviews Complaints that have been reported to the provider to assure that they followed their policies and procedures and the Medicaid provider agreement.

5. The Complaint Tool is analyzed at the aggregate level on a quarterly basis to identify and assess any trends in types or frequency of Complaints, including trends with specific providers or provider types, to determine if systemic issues need to be addressed by the BLTCC.

6. The Idaho Commission on Aging meets quarterly with Medicaid and shares information regarding open/ongoing Complaints. The team discusses interventions taking place, provides status updates and next steps are determined. Idaho Commission on Aging case workers cell phone numbers are made available to Medicaid. If a meeting is needed more frequently than quarterly, then the team has the ability to meet immediately to staff a case.

Additional Information for Oversight of Complaints for MMCP and Idaho Medicaid Plus participants:

The Department will ensure that the MCE will implement and maintain a Complaint Resolution and Tracking System for all Complaints. The system shall include safeguards to prevent abuse, neglect, and exploitation. For Complaints, the Department will ensure that the MCE has a system in place allowing providers, participants, and authorized representatives of participants the opportunity to express dissatisfaction with the general administration of the plan and services received. The MCE will have a system in place allowing network providers and/or MCE staff to document incidents of health and safety issues impacting a participant.

The Department will ensure that the MCE:
1. Includes components that allow the MCE to analyze the Complaint, and provide reports as requested by the Department in the Complaint Resolution and Tracking System.
2. Complies with Idaho Code § 39-53, "Adult Abuse, Neglect and Exploitation Act” in all aspects of its Complaint Resolution and Tracking System.
3. Has internal controls to monitor the operation of the Complaint Resolution and Tracking System.
4. Track all Complaints, whether they are resolved or in the process of resolution, and report the information to the Department.
5. Analyze the Complaints and utilize the information to improve business practices.
6. Have a methodology for reviewing and resolving Complaints received, including timelines for the process.
7. Ensure complainants are sent written notifications of Complaint resolutions that have all of the required information.
8. Address Complaints that may need resolution at the Department level.
9. Ensure that all documents pertaining to Complaint investigations and resolutions are preserved in an orderly and accessible manner.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will*

display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The state Medicaid agency is responsible for detecting the unauthorized use of restraints. Oversight is conducted through the following processes:

1) Complaint and Critical Incident reporting process
2) Provider quality assurance review
3) Annual nurse reviewer home visit

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification

are available to CMS upon request through the Medicaid agency or the operating agency.

Effective July 1, 2016, the only restrictive interventions that may be implemented by an A&D waiver provider include risk mitigation strategies and exceptions related to the HCBS setting qualities described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," that are in place to ensure the health and safety of the participant. The A&D waiver program does not permit the use of aversive methods to modify behavior.

If an HCBS setting quality poses a health or safety risk to the participant or those around the participant, goals must be identified with strategies to mitigate the risk. These goals and strategies must be documented in the person-centered plan. If a strategy included a restrictive intervention, the restrictive intervention applied is unique to each individual and is based on their specific needs. Risk mitigation strategies and exceptions are determined through the person-centered planning process and agreed to by the participant and/or guardian.

Setting qualities that may warrant risk mitigation include:
* Full integration and access to the community, including:
    - Freedom to control personal resources
    - Freedom to work in competitive integrated settings
    - Freedom to engage in community life
    - Freedom to receive services in the community
- Right to privacy
- Autonomy in making choices, including daily activities, physical environment, and with whom to interact
- Opportunities for choice regarding services and supports

Setting qualities that may warrant an exception include:
- Lockable bedroom or living unit doors
- Choice of roommate
- Freedom to furnish and decorate living space(s)
- Freedom and support to control schedules and activities
- Access to food
- Ability to have visitors at any time
- Physically accessible setting

All service plans must include an assessment of any risks that may interfere with the participant's needs being met, in addition to potential health and safety risks with a corresponding back-up plan to ensure those risks are addressed. In the event of a health and safety risk that is associated with an HCBS setting requirement, the service plan must also reflect any corresponding risk mitigation strategies in place that are appropriate to the individual's assessed need(s) and that individual has provided informed consent.

For Certified Family Home or Residential Assisted Living Facility participants who, due to health or safety concerns, require an exception to the provider owned or controlled residential setting qualities described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," the service plan must include documentation of the participant's assessed need(s) related to the exception, interventions, and supports implemented prior to the exception and prior methods that did not work in addressing the participant's needs, a clear description of the intervention, evidence of regular data collection to monitor the effectiveness of the modification, time limits for periodic review to determine if the exception is still necessary, informed consent of the participant, and an assurance of no harm. Providers will be required to submit a request for review and approval of an exception to the Bureau of Long Term Care within 30 days of implementing a modification. The Nurse Reviewer will approve the request, deny the request, or ask for additional information to support the request. The provider must keep documentation of the approval with the participant's service plan.

The BLTC will monitor the use of risk mitigation strategies and exceptions during the annual redetermination process. During the redetermination process, the Nurse Reviewer examines the individual's service plan and will document whether or not, based on his or her interaction with the participant and observation of the participant's residence or service setting (as applicable), a risk mitigation strategy or exception has been implemented by the service provider. If the Nurse Reviewer determines that a risk mitigation strategy or exception has been implemented, he or she must indicate if it was documented appropriately on the service plan and if Department approval was obtained, if applicable. If a restrictive intervention is implemented inappropriately or without Department approval (if applicable), this is noted in

the Quality Survey. The results of the Nurse Reviewer Home Visit process are transmitted to the provider upon completion and immediate remediation of issues is requested as needed. Regional QA/QI staff and the QA/QI Program Manager also review compiled data on a quarterly basis to identify potential trends in deficiencies. Corrective action is requested for individual occurrences or for repeated issues when necessary.

Regional QA/QI staff will also monitor the use of risk mitigation strategies and exceptions during bi-annual provider quality reviews. During these reviews, a sample of service plans is examined. Provider quality reviews will include an assessment of appropriate documentation of risk mitigation strategies and participant consent.

Certified Family Home service plans are reviewed by regional staff prior to authorization. This will permit staff to identify and remediate any deficiencies or issues if risk mitigation strategies or exceptions are applied or documented inappropriately.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The state Medicaid agency and the MCE (for participants enrolled in the MMCP or Idaho Medicaid Plus) are responsible for detecting the unauthorized or inappropriate use of restrictive interventions. Oversight is conducted through the following processes:

1) Complaint reporting process, including the Department's review of reports submitted by the MCE related to complaints.
2) Provider quality assurance reviews are conducted biannually by Quality Assurance staff.
3) Annual redetermination process.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The state Medicaid agency is responsible for detecting the unauthorized use of seclusion. Oversight is conducted through the following processes:

1) Complaint reporting process, including the Department's review of reports submitted by the MCE related to complaints.
2) Provider quality assurance reviews
3) Annual redetermination process.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Monitoring varies by place of service delivery.
If a participant is in their own home and they require assistance with the administration of their medications, the provider (caregiver) may assist in accordance with the Board of Nursing's rule in IDAPA 23.01.01.490.05. The nurse reviewers will monitor with the annual reassessment.

Ongoing: The attendant will contact the provider, family, physician, nurse reviewer, or MCE registered nurse or Care Coordinator if they have any concerns regarding the participant's medications or change in participant condition.

In a Certified Family Home:
If the resident is responsible for administering his own medication without assistance, a written approval stating that the resident is capable of self-administration must be obtained from the resident's primary physician or practitioner of the healing arts. The resident's record must also include documentation that a licensed nurse or other qualified professional has evaluated the resident's ability to self-administer medication and has found that the resident:
a. Understands the purpose of the medication;
b. Knows the appropriate dosage and times to take the medication;
c. Understands expected effects, adverse reactions or side effects, and action to take in an emergency; and
d. Is able to take the medication without assistance.

The certified family home must provide assistance with medications to residents who need assistance. Assistance shall be provided in accordance with the Idaho Board of Nursing's rules in IDAPA 23.01.01. Prior to assisting residents with medication, the following conditions must be in place:
a. Each person assisting with resident medications must be an adult who successfully completed and follows the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing, or other Department-approved training.
b. The resident's health condition is stable;
c. The resident's health status does not require nursing assessment before receiving the medication nor nursing assessment of the therapeutic or side effects after the medication is taken;
d. The medication is in the original pharmacy-dispensed container with proper label and directions, or in an original over-the-counter container, or the medication has been placed in a unit container by a licensed nurse. Proper measuring devices must be available for liquid medication that is poured from a pharmacy-dispensed container;
e. Written and oral instructions from the licensed physician or other practitioner of the healing arts, pharmacist, or nurse concerning the reason(s) for the medication, the dosage, expected effects, adverse reactions or side effects, and action to take in an emergency have been reviewed by the staff person; Written instructions are in place that outline required documentation of medication assistance, and whom to call if any doses are not taken, overdoses occur, or actual or potential side effects are observed; and
f. Procedures for disposal/destruction of medications must be documented and consistent with procedures outlined in the "Assistance with Medications" course.

The Certified Family Home operator will monitor medication as an ongoing responsibility.

In a Residential Assisted Living Facility, the facility RN is responsible for monitoring. Assistance shall be provided in accordance with the Idaho Board of Nursing's rules in IDAPA 23.01.01. They conduct the monitoring monthly. Ongoing: The attendant care staff will contact the facility nurse if they have any concerns regarding the participant's medications or the participant has a change in condition.

The licensed professional nurse must assess and document for each resident:
01. Resident Response to Medications and Therapies. Conduct a nursing assessment of each resident's response to medications and prescribed therapies.

02. Current Medication Orders. Assure the residents' medication orders are current by verifying that the medication listed on the medication distribution container, including over-the-counter-medications as appropriate, are consistent with physician or authorized provider orders. A copy of the actual written, signed. and dated orders must be present in each resident's care record.

03. Resident Health Status. Conduct a nursing assessment of the health status of each resident by identifying symptoms of illness, or any changes in mental or physical health status.

04. Recommendations. Make recommendations to the administrator regarding any medication needs, other health needs requiring follow up, or changes needed to the Negotiated Service Agreement.

05. Progress of Previous Recommendations. Conduct a review and follow-up of the progress on previous recommendations made to the administrator regarding any medication needs or other health needs that require follow up. Report to the attending physician or authorized provider and state agency if recommendations for care and services are not implemented that have affected or have the potential to affect the health and safety of residents.

06. Self-Administered Medication. Conduct an initial nursing assessment on each resident participating in a self-administered medication program as follows:
a. Before the resident can self-administer medication to assure resident safety; and
b. Evaluate the continued validity of the assessment to assure the resident is still capable to safely continue the self-administered medication for the next ninety (90) days.

07. Medication Interactions and Usage. Conduct a review of the residents use of all prescribed and over-the-counter medications for side effects, interactions, abuse, or a combination of these adverse effects. The nurse must notify the resident's physician or authorized provider of any identified concerns.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

A. Residents in their own homes will be assessed initially and annually thereafter through the UAI assessment process for current medications and assistance needed. An agency registered nurse (RN) will review the current list of medications with the participant during the service planning process and when any changes in medications occur. Any potentially harmful practices would be identified at this time. Communication with the participant's physician would be initiated. If needed, agency RN oversight may be provided more frequently through authorized nursing visits from a provider agency.

B. Residents in a Certified Family Home are assessed and a quality control check done annually by Licensing and Certification staff. Identified harmful practices are addressed with the participant's physician immediately. Follow up would be done by Medicaid staff or MCE staff with the assistance of the Certified Family Home operator.

C. Residents in a Residential Assisted Living Facility are monitored by the facility RN. Surveys by the Division of Licensure and Certification would have oversight of the medication on the survey schedule. Medicaid Staff would monitor during the annual assessment and redetermination. Follow up would be monitored by the RN who discovered the problem, either the facility contract RN or staff from Division of Licensure and Certification. Division of Licensure and Certification would ultimately have oversight and follow up as this infraction could result in an action against the license.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of**

medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

If a participant is in their own home and they require assistance with the administration of their medications, the provider (caregiver) may assist in accordance with the Board of Nursing's rule in IDAPA 23.01.01.490.05. The nurse reviewers will monitor with the annual reassessment.

In a Certified Family Home: IDAPA 16.03.19
If the resident is responsible for administering his own medication without assistance, a written approval stating that the resident is capable of self-administration must be obtained from the resident's primary physician or other practitioner of the healing arts. The resident's record must also include documentation that a licensed nurse or other qualified professional has evaluated the resident's ability to self-administer medication and has found that the resident:
a. Understands the purpose of the medication;
b. Knows the appropriate dosage and times to take the medication;
c. Understands expected effects, adverse reactions or side effects, and action to take in an emergency; and
d. Is able to take the medication without assistance.

In a Residential Assisted Living Facility, the RN will: IDAPA 16.03.22 Conduct an initial nursing assessment on each resident participating in a self-administered medication program as follows:
a. Before the resident can self-administer medication to assure resident's safety; and
b. Evaluate the continued validity of the assessment to assure the resident is still capable to safely continue the self-administered medication for the next ninety (90) days.

Medication administration must comply with IDAPA 23.01.01, "Board of Nursing". IDAPA 23.01.490 allows unlicensed assistive personnel to administer medications in specified circumstances.

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

Providers must maintain a comprehensive medication log that includes any medication errors as defined by the professional licensing board and best practice guidelines.

Medication administration under the scope of the Nurse Practice Act must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. In Idaho, providers are required to record, but not report errors unless requested by the state. Medication errors may be reviewed if reported to the Department through the Complaint and Critical Incident reporting system. Medication errors include such errors as wrong dose, wrong time, wrong route, wrong medication, and missed medication.

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The following Department of Health & Welfare Divisions are responsible for the monitoring of waiver providers in the administration of medications to waiver participants.

1. Division of Licensing and Certifications (Certified Family Homes and Residential Assisted Living Facilities)

2. Division of Medicaid - Aged and Disabled in home provider agencies

Performance Monitoring:

Providers are required to record, but not report medication errors unless requested by the state. Data related to medication errors is collected if identified as a complaint on the Complaint and Critical Incident Reporting System. Medication errors are reviewed when reported to the Department through the Complaint and Critical Incident reporting system. If a trend or pattern is identified, the Department's Quality Improvement Specialist will review provider records, and discuss complaint and remediation with the provider agency as appropriate, which helps to prevent re-occurrence. Complaints or Critical Incidents beyond the jurisdiction of the Department are referred to the appropriate agency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number of substantiated instances of abuse, neglect, exploitation and unexplained death that were remediated. a. Numerator: Number of substantiated instances of abuse, neglect, exploitation and unexplained death that were remediated. b. Denominator: Number of substantiated instances of abuse, neglect, exploitation and unexplained death.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of reported instances of abuse, neglect, exploitation and unexplained death that were investigated. a.Numerator: Number of reported instances of abuse, neglect, exploitation and unexplained death that were investigated. b.Denominator: Number of reported instances of abuse, neglect, exploitation and unexplained death.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of all incidents investigated according to the state critical event or incident timeframes. a. Numerator: Number of incidents investigated according to the state critical event or incident timeframes. b. Denominator: Number of incidents investigated.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of service plans with restrictive interventions (modifications to HCBS setting qualities) that were approved according to criteria. a. Numerator: Number of service plans with restrictive interventions that were approved according to criteria. b. Denominator: Number of service plans reviewed with restrictive interventions.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: MCE	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of substantiated complaints associated with restrictive interventions that were remediated. a. Numerator: Number of substantiated complaints associated with restrictive interventions that were remediated. b. Denominator: Number of substantiated complaints associated with restrictive interventions.

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

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participants who received an annual wellness examination. a. Numerator: Number of participants who received an annual wellness examination. b. Denominator: Number of participants receiving waiver services.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

The following are the strategies employed by the State to discover/identify problems/issues regarding participant safeguards:

1. Nurse Reviewer Home Visit Process: Nurse Reviewers (NR) complete a NR home visit, and conduct a review of the participant's service plan and interview with each participant on the A&D Waiver during the annual redetermination assessment. The results of the home visit are entered into a data management tool and analyzed quarterly. Results are also sent to the provider for immediate remediation if necessary. Provider corrective plans are requested when needed. The BLTC Quality Survey addresses the following aspects of service plan development and service delivery:

a. Service plans address participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

b. Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

c. Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.

d. Participant experience regarding aspects of the service plan development. For example, participants are asked if they had input into the days and times that they will receive services.

e. Service plan is signed by the participant (and/or family or legal representative as appropriate).

f. Service plan is signed by the provider.

g. If necessary, any mitigation strategies needed to ameliorate risk to the participant associated with the home and community-based setting requirements described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" and evidence of participant consent.

h. If necessary, any exception to the provider owned or residential HCBS qualities is documented appropriately, and evidence of participant consent and Department approval is included with the participant's plan.

2. Provider Quality Assurance Reviews. The Medicaid Quality Improvement Specialist or designee reviews each waiver provider per the provider qualification schedule in Appendix B. This review includes review of a random sample of participant records and monitors the following aspects of the service plan and service delivery:

a. Plan includes specific type, amount, frequency, & duration of services to be provided.

b. Plan includes supports provided by family, friends, community, etc.

c. Plan includes participant goals.

d. Plan promotes progress, prevention of regression/maintenance of skills, etc.

e. Plan includes providers of waiver services.

3. Complaint & Critical Incident Process and Reporting: Nurse Manager, Program Manager, or Quality Improvement Specialist (NM, PM, or QI Specialist) or designee investigate complaints and critical incidents and enter them into the Complaint/Critical Incident Tracking Tool. They are responsible for participant and provider remediation.

4. MCE: The IDHW ensures that the MCE operates an Incident Resolution and Tracking System as described in Appendix G1-e of this waiver application and as required in the MCE's contract with the Department.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The Department remediates individual problems regarding participant safeguards as they are discovered via the following quality management strategies:

1. Nurse Reviewer Home Visit Report: A copy of the Quality Survey with results is sent to the provider during the redetermination process. Individual provider data is also compiled and analyzed quarterly by the QI Specialist and provider corrective action plans are requested and monitored as needed.

2. Participant Experience Data: Participant experience data is collected in the NR Home Visit process. Any specific participant complaints/incidents are referred to the Complaint Reporting process and are followed up by the NM or PM as appropriate.

3. Complaint Process and Reporting: The Bureau of Long Term Care Committee (BLTCC) or designee identifies and addresses any statewide resource or program issues identified in the analysis of this information. The result of this analysis is reported through the BLTCC minutes and recommended program changes or system improvement processes are sent to the Bureau Leadership Team (BLT) for review. Final approval is decided upon by the Central Office Management Team (COMT).

3. The non-licensed/non-certified provider is responsible for the development and implementation of a quality assurance program which assures service delivery consistent with applicable rules. Results of individual quality assurance reviews conducted by IDHW shall be transmitted to the provider within 45 days of a review being completed. If deficiencies have been identified by the review, the provider agency shall submit to IDHW a corrective action plan for addressing the identified deficiencies. This corrective action plan shall be submitted to IDHW within 45 calendar days of receiving the results of a quality assurance review. Upon request, an agency shall also forward to IDHW the results of any implemented corrective action plan.

4. The Department will ensure that the MCE has safeguards in place to prevent abuse, neglect and exploitation, as required by contract.

5. The IDHW Contract Monitor will issue a Monitoring Report to the MCE that identifies in writing the Performance Indicator(s) monitored, and that summarizes the preliminary results with the MCE. The MCE utilizes the same sampling methods as the IDHW for performance and quality improvement measures. Upon request by the MCE, the IDHW will meet with the MCE within ten (10) business days of their receipt of the Monitoring Report regarding the results. The MCE may dispute the findings via written appeal to the Contract Monitor within ten (10) business days of issuance of the report. The MCE must specifically address each disputed finding and justification for the appeal of the finding. The MCE is required to provide all documents necessary to dispute monitor results with its written appeal. The IDHW will render a final written decision on the appeal to the MCE within ten (10) business days of receipt of the MCE's dispute information, unless the parties agree in writing to extend the decision period.

If the MCE does not dispute the findings, the MCE shall have ten (10) business days from the date of the IDHW's monitoring report to cure the deficiencies found. If the MCE appeals the monitoring report, the MCE shall have ten (10) business days from the date of the IDHW's final written decision to cure the deficiencies. If the IDHW is not satisfied that the MCE has resolved the deficiencies, or made substantial progress toward resolution, the IDHW may assess the amounts listed in the Scope of Work as liquidated damages for each day the deficiency remains uncured.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state

spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The following is the processes for trending, prioritizing, and implementing system improvements:

1. The Division of Medicaid, Bureau of Long Term Care or designee has a quality management committee whose function is to review quality improvement strategy findings and analysis (including trending), formulate remediation recommendations, and identifying and addressing any statewide resource or program issues identified in the QA/QI business processes. The quality management team hereafter referred to as the Bureau of Long Term Care Committee (BLTCC) or designee, is a team that includes the Bureau Chief, Program Managers, and Policy staff.

2. The results of the BLTCC or designee findings and recommendations are reported through the BLTCC minutes and reports, and are then presented to the Bureau Leadership Team (BLT).

3. The BLT is responsible for reviewing BLTCC or designee and other Medicaid program reports, analyses and recommendations, considering Division-wide resources, coordination issues, and strategies. The Central Office Management Team (COMT) then makes final system-wide change decisions.

4. Nurse Managers and Program Managers are responsible for remediating any specific caseload performance issues and/or training and educating staff on any adopted statewide design changes.

5. The Quality Manager(s) are responsible for training and educating Quality Improvement Specialists on any adopted statewide design changes.

As part of the system improvement process, the following quality improvement reports are compiled:

Internal File Audit Report: Quarterly. BLTC Nurse Managers and Program Managers monitor staff performance in the administration of the Aged and Disabled, Home and Community Based Waiver. The information from the Internal Audit process is critical in the monitoring of the following HCBS Waiver assurances:

A. The level of care of enrolled participants is reevaluated at least annually or as specified in the approved waiver.
B. The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.
C. The BLTC Internal Audit forms and process are used by the Nurse Manager or Program Manager to review work completed by the Nurse Reviewers, QA Specialists, and Support Staff:

Complaint and Critical Incident Report: Quarterly. All complaints and critical incidents received are recorded in the SharePoint data system and require specific dates, nature of complaint/critical incident, narrative, referrals when necessary, a classification of substantiated or unsubstantiated, and a closure date. The Department will ensure that the MCE will submit a provider and participant complaints report and a critical incident resolution report on a quarterly basis.

Nurse Reviewer Home Visit Report: Quarterly. The Nurse Reviewer (NR) Home Visit Form is completed by the NR on Aged and Disabled (A & D) Waiver and Adult Personal Care Services (PCS) redeterminations. The information gathered from the aggregate data for NR Form statewide is critical in monitoring the following HCBS Waiver Assurances under Level of Care, Service Plan, and Administrative Authority.

Provider Review Report: Quarterly. BLTC Provider Agencies who have active billing of selected waiver services in the last two (2) years are reviewed on a two (2) year cycle, but not later than two (2) years and thirty (30) days past the previous review. BLTC Agency Quality Assurance reviews may need to be conducted more often in some circumstances. The Department will ensure that the MCE requires providers to meet the minimum Medicaid provider qualifications prior to their inclusion on the provider enrollment file and/or before payment of their claim.

Redetermination Report: This report is the total number and percent of annual redeterminations that were completed within 364 days of the previous A & D Waiver eligibility assessment.

Quality improvement reports are communicated to the Personal Assistance Oversight Committee and the Medical Care Advisory Committee at their quarterly meetings.

The Personal Assistance Oversight Committee includes providers of personal assistance services, participants of such services, advocacy organizations representing such participants, and other interested parties. At least 51% of the committee membership is participants or their representatives.

The Medical Care Advisory Committee membership that includes licensed physicians and other representatives of health professions who are familiar with the medical needs of low income population groups and with the resources available and required for their care. There are also members of consumer groups including medical assistant participants and consumer organizations.

Nurse Reviewer Home Visit results are sent to the provider with the redetermination results.

Provider review results are sent to the providers during the provider QI Review Process.

For the MMCP and Idaho Medicaid Plus, the MCE will develop a QM/QI program and implement and maintain a written comprehensive QM/QI Plan that clearly defines its quality improvement structures and processes, and assigns QM/QI responsibilities to qualified individuals. The QM/QI Plan must include the following:

- A process to immediately remediate all individual findings identified through its monitoring process;
- A process to track and trend all individual findings;
- A process to identify systemic issues of poor performance and/or non-compliance;
- A process to implement remediation and strategies to improve processes and resolve areas of non-compliance; and
- A process to measure the success of remediation and strategies in addressing identified issues.

The MCE's QM program shall include policies and procedures that document processes or methods through which the Health Plan ensures clinical quality, access and availability of services, continuity and coordination of care, and that include all related contractual requirements.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The following is the State's process for monitoring and analyzing the effectiveness of system design changes:

1. When the Central Office Management Team (COMT) approves system design changes, the Bureau of Long Term Care Committee (BLTCC) or designee monitors the implementation and analysis of the effectiveness of the design change.

2. It is the responsibility of the Quality Assurance Team to review QI processes and instruments through monthly conference calls (supported by team minutes), to oversee the day to day QI processes, and report to the BLTCC. The Quality Assurance Team includes a Program Manager and Quality Improvement Specialists. The Quality Assurance Team identifies and reports trends to the Quality Improvement Team, which is a team comprised of the Bureau Chief, Program Managers, and Policy staff. The Quality Improvement Team is responsible for analyzing the effectiveness of existing quality designs and making targeted system improvements. If a system improvement is needed, it is supported through a Quality Improvement Action Plan. This action plan identifies the design change(s) to be implemented from discovery, to remediation and system improvement, along with roles/responsibilities and a targeted completion date. The Quality Improvement Action Plan is a coordination tool for follow through activities when a quality change is needed.

3. Quality Improvement Action Plans are reviewed by the BLTCC or designee for approval, and a recommendation is sent to the COMT for direction regarding implementation.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The process to periodically evaluate the Quality Improvement Strategy is as follows:

1. The Department is consistently evaluating and improving processes and systems on an ongoing basis. Each year, the Department improves services to waiver participants by using the numerous data collection points, appropriate analysis and prioritization techniques, evaluation and feedback from various groups.

2. Annually, the Quality Improvement Strategy is reviewed by the Quality Assurance Team, Quality Improvement Team, BLTC Committee, then submitted to Bureau Leadership Team and Quality Assurance Oversight committee.

3. The Department ensures that the MCE's quality improvement program includes 1) An evaluation of the effectiveness of the system interventions designed to improve quality, and 2) Processes to demonstrate how the results of the quality management program are used to address service delivery, provider, and other quality management issues as they are identified and to improve the quality of physical health, behavioral health, and long term care.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The following are the methods that the State employs to ensure the integrity of payments made for waiver services:

1. Nurse Reviewer must authorize all services reimbursed by Medicaid under the Aged and Disabled Waiver Program before the services are rendered. Prior authorizations for approved services are entered into the Medicaid Management Information System (MMIS) by Medicaid staff. Approved prior authorizations are valid for one (1) year from the date of prior authorization by Medicaid, unless otherwise indicated. Claims are adjudicated by MMIS in accordance with Federal guidelines and Idaho policies. This includes extensive claim edit and audit processing, claim pricing, and claim suspense resolution processing.

2. The Medicaid Program Integrity Unit processes support the post-payment analysis of expenditures to identify potential misuse, abuse, quality of care, and treatment outcomes in Medicaid. Functions specifically supported by these processes include the traditional surveillance and utilization review features of the MMIS, retrospective drug utilization review, and outcome-oriented analysis regarding quality of care assessments.

3. The Department conducts performance monitoring of the MMIS contract to ensure that claims are adjudicated by the MMIS and Fiscal Agent contractor in accordance with federal guidelines and Idaho Policies. In addition, Idaho is participating in the Payment Error Rate Measurement (PERM) Program beginning FY 2006.

4. All records are maintained by the MMIS and are available for review during post-payment audits. These records include: all claims submitted either electronically or on paper, all remittance and status reports which accompany provider payments; and all adjustment request forms.

5. The State requires the contractor to contract with, and pay for, an independent certified public accounting firm to perform an annual audit of the contractor's services to the State in compliance with AICPA Statement on Auditing Standards number 70 (Reports on the Processing of Transactions by Service Organizations).

6. The Department ensures that the MCE has an approved fraud and abuse compliance plan that includes, in addition to all other contractual obligations:
A) A risk assessment of the MCE's various fraud and abuse/program integrity processes,
B) Descriptions of specific controls in place for prevention and detection of potential or suspected fraud and abuse, such as automated pre-payment claims edits, automated post-payment claims edits, and desk audits on post-processing review of claims,
C) Methods for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports,
D) A requirement that any confirmed or suspected Provider fraud and abuse under Federal or State law be reported to the IDHW and the Medicaid Fraud Control Unit (MFCU) and that participant fraud and abuse is reported to the MFCU,
E) Work plans for conducting both announced and unannounced site visits and field audits to providers defined as high risk providers with cycle/auto billing activities, and providers offering durable medical equipment (DME) or non-medical transportation services; to ensure services are rendered and billed correctly.

7. The Department will ensure that the MCE ensures the services furnished by providers were appropriate and medically necessary, authorized, and billed in accordance with the MCE's requirements. This includes monthly review of a random sample of no fewer than two and one-half percent (2 1/2%) of participants to ensure that such participants received the services for which providers billed with respect to such participants.

8. The Department will ensure that the MCE has reconciled participant eligibility data with capitation payments and verified that the MCE has an enrollment record for all participants for whom the MCE has received a capitation payment.

9. The Department will ensure that the MCE reports on the results of the internal audit of the random sample of all processed, paid, or pended claims, and that it reports on the number and percent of claims that are paid accurately.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of claims paid according to the posted fee schedule a. Numerator: Number of claims paid according to the posted fee schedule b. Denominator: Paid claims (by procedure code) for one week of each calendar quarter

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Ad-hoc paid claims report

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of service delivery records reviewed that support claims paid for waiver services. a. Numerator: Number of service delivery records reviewed that support claims paid for waiver services. b. Denominator: Number of claims billed for waiver services in the sample.

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

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*

☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *+/- 5%, Confidence Level = 95%*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of reports of potentially fraudulent activity by MCE waiver providers that were investigated by the MCE. a. Numerator: Number of reports of potentially fraudulent activity by MCE waiver providers that were investigated by the MCE. b. Denominator: Number of reports of potentially fraudulent activity.

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

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

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of posted rates that are consistent with the approved waiver rate methodology. a.Numerator: Number of posted rates (by procedure code) that are consistent with the approved waiver rate methodology. b.Denominator: Number of procedure codes derived from rate methodologies in the approved waiver.

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

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

Data Aggregation and Analysis:

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

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

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

The following are the strategies employed by the State to discover/identify problems/issues regarding financial accountability.

1. MMIS system-level audits are reviewed by contractor personnel to prevent duplicate transactions from being paid more than once, regardless of how many times the service is billed. Yearly audit reports are submitted to the Department.
a. The Department conducts monitoring of the MMIS contract to ensure that claims are adjudicated by the MMIS in accordance with Federal guidelines and Idaho policies.
b. Idaho is participating in the PERM program beginning FY 2006.
c. The State requires the MMIS contractor to contract with and pay for an independent CPA firm to perform an annual audit of the contractor's services to the State in compliance with AICPA Statement on Auditing Standards number 70 (Reports on the Processing of Transactions by Service Organizations).
d. Provider corrective action is requested when appropriate.

2. Possible provider fraudulent billing patterns that are identified during the following Quality Improvement processes are investigated and forwarded to the Medicaid Fraud Unit. These issues are documented and tracked within the Complaint System. Provider corrective action is requested when appropriate.
a. Nurse Reviewer Home Visit Process
b. Provider Quality Assurance Reviews
c. Complaints regarding possible fraud received by the Department

3. The Department will ensure that the MCE complies with all its requirements listed in this Appendix, and with all other contractual requirements related to financial accountability.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

The following is the State's methods for remediation/fixing individual problem as they are discovered.

1. The Bureau of Long Term Care Committee (BLTCC) or designee identifies and addresses any statewide resource or program issues identified in the analysis information. The result of this analysis is reported through the BLTCC minutes, and recommended program changes are sent to the Medicaid Quality Management Oversight Committee for approval.

3. The Bureau Leadership Team (BLT) reviews BLTCC or designee and other Medicaid program report analyses and recommendations, considers Division-wide resources, coordination issues and strategies. This information is used by the Central Office Management Team (COMT) to make final system-wide change decisions.

4. The non-licensed/non-certified provider is responsible for the development and implementation of a quality assurance program which assures service delivery consistent with applicable rules. Results of individual quality assurance reviews conducted by IDHW shall be transmitted to the provider within 45 days of a review being completed. If deficiencies have been identified by the review, the provider agency shall submit to IDHW a corrective action plan for addressing the identified deficiencies. This corrective action plan shall be submitted to IDHW within 45 calendar days of receiving the results of a quality assurance review. Upon request, an agency shall also forward to IDHW the results of any implemented corrective action plan.

5. The IDHW Contract Monitor will issue a Monitoring Report to the MCE that identifies in writing the Performance Indicator(s) monitored, and that summarizes the preliminary results with the MCE. The MCE utilizes the same sampling methods as IDHW for performance and quality improvement measures. Upon request by the MCE, IDHW will meet with the MCE within ten (10) business days of their receipt of the Monitoring Report regarding the results. The MCE may dispute the findings via written appeal to the Contract Monitor within ten (10) business days of issuance of the report. The MCE must specifically address each disputed finding and justification for the appeal of the finding. The MCE is required to provide all documents necessary to dispute monitor results with its written appeal. The IDHW will render a final written decision on the appeal to the MCE within ten (10) business days of receipt of the MCE's dispute information, unless the parties agree in writing to extend the decision period.

If the MCE does not dispute the findings, the MCE shall have ten (10) business days from the date of the IDHW's monitoring report to cure the deficiencies found. If the MCE appeals the monitoring report, the MCE shall have ten (10) business days from the date of IDHW's final written decision to cure the deficiencies. If the IDHW is not satisfied that the MCE has resolved the deficiencies, or made substantial progress toward resolution, the IDHW may assess the amounts listed in the Scope of Work as liquidated damages for each day the deficiency remains uncured.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

- (●) ***No***
- ( ) ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Department provides public notice of significant reimbursement changes in accordance with 42 CFR § 447.205 (made applicable to waivers through 42 CFR § 441.304(e)). The Department publishes public notice of proposed reimbursement changes in multiple newspapers throughout the State and on the Department's website at www.healthandwelfare.idaho.gov. Copies of public notices and text of proposed significant reimbursement changes are made available for public review on Department's website and during regular business hours at agency locations in each Idaho county as identified in each public notice. Additionally, payment rates are published on our website at www.healthandwelfare.idaho.gov for the public to access.

The Department provides opportunity for meaningful public input related to proposed reimbursement changes in accordance with 42 CFR § 441.304(f). The Department solicits comments from the public (including beneficiaries, providers and other stakeholders) through its public notice process and through public hearings related to the proposed reimbursement changes. The public is given the opportunity to comment on the proposed reimbursement changes for at least 30 days prior to the submission of a waiver amendment to CMS. Additionally, when administrative rules are promulgated in connection with reimbursement changes, the proposed rules are published in the Idaho Administrative Bulletin and the public is given the opportunity to comment.

Waiver service providers will be paid on a fee-for-service basis as established by the Department depending on the type of service provided. The Bureau of Financial Operations is responsible for rate determinations. The Department will ensure that the MCE reimburses providers at a rate no less than the current Medicaid Provider rates.

The Department solicits comments at public hearings when administrative rules related to rate determination methods are promulgated. Administrative rules are published when there are changes to rate determination methods. The public may submit comments on these rules for 21 days after the date of publishing.

Pursuant to 42 CFR §447.205, the Department gives notice of its proposed reimbursement changes by publishing legal notices throughout the State to inform providers about any change. Additionally, payment rates are published on our website at www.healthandwelfare.idaho.gov for participants to access.

Please see below for services and reimbursement methodology information:

Adult Day Health and Home Delivered Meal Services. The initial rate was set in 1999 based on time studies in nursing facilities.

Residential Habilitation. The rate model used to develop Residential Habilitation rates is described in Idaho Administrative Code (IDAPA) 16.03.10.037.04. The Department surveyed residential habilitation providers to identify the actual cost of providing residential habilitation services (Cost Survey). Reimbursement rates are based on surveyed data and derived using a combination of four cost components – direct care staff wages, employer related expenditures, program related costs, and indirect general and administrative costs.

The individual components of the rate are determined as follows: (1) the direct care staff wage component is determined using either the wage for a comparable Bureau of Labor Statistics (BLS) occupation title, or the weighted average hourly rate from surveyed data if there is no comparable BLS occupation title; (2) the employer related expenditure component is determined by multiplying the direct care staff wage by the cumulative percentage of employer costs for employee compensation identified by BLS for the West Region, Mountain Division and the internal revenue service employer cost for social security benefit and Medicare benefit; (3) the program related cost component is determined by identifying the 75th percentile of the ranked program related costs from the surveyed data; and (4) the indirect general and administrative cost component is determined by identifying the 75th percentile of the ranked general and administrative costs from the surveyed data.

Consultation Services, Personal Emergency Response System Services, Day Habilitation and Supported Employment - The initial rate was set back in 1999 based on time studies in nursing facilities. Going forward, the rate is set based on a labor model that uses a Staff Support Hour (SSH) rate approach, which involves developing a single rate for a unit of staff time spent providing services for an individual.

Attendant Care, Homemaker Services, Companion Services, Chore Services, and Respite Care Services – The rate model used to develop rates for these services is described in Idaho Administrative Code (IDAPA) 16.03.10.307.04. Section

16.03.10.037.02 requires the Department to conduct a survey when there are identified access issues. As a result, the rate was developed from a cost survey conducted in 2016. The surveyed results of four cost components were combined to arrive at an hourly unit rate. Since these services are identified as personal care service, section 16.03.10.307 followed. The hourly rate calculation was determined using the following reimbursement methodology. The Department followed IDAPA 16.03.10.307.04.a in calculating a direct care wage. This section states the Department will establish Personal Assistance Agency rates for personal assistance services based on the WAHR. The Department followed IDAPA 16.03.10.307.04.b in calculating a supplemental component. This section states the Department will calculate a supplemental component using costs reported for travel, administration, training, and payroll taxes and fringe benefits (employment related expenditures, program related costs, and indirect general and administrative costs).

Adult Residential Care - This service is paid on a per diem basis based on the number of hours and types of assistance required by the participant as identified in the Uniform Assessment Instrument.

Non-medical Transportation - A study is conducted that evaluates the actual costs of fuel reasonably incurred by the typical non-commercial transportation provider whose personal vehicle averages fifteen (15) miles per gallon.

Specialized Medical Equipment & Supplies - For codes that are manually priced, including miscellaneous codes, a copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer is required. Reimbursement will be seventy-five percent (75%) of MSRP. If pricing documentation is the invoice, reimbursement will be at cost plus ten percent (10%), plus shipping (if that documentation is provided). For codes that are not manually priced, the rate is based on the Medicaid fee schedule price.

Environmental Accessibility Adaptations - For adaptations over $500, three bids are required if it is possible to obtain three bids. The lowest bid which meets the participant's needs is selected.

Nursing Services - These services are paid on a uniform reimbursement rate based on an annual survey conducted by the Department.

The contract between the Department and the MCE shall be a firm fixed fee, indefinite quantity contract for services specified in the Scope of Work. For payment purposes, a capitated payment is calculated based on the current eligible MMCP or Idaho Medicaid Plus participant count multiplied by the per member per month (PMPM) figure and is intended to be adequate to support participant access to, and utilization of covered services, including administrative costs. The total PMPM payment is comprised of two (2) components; the Medical capitation and the blended Long Term Services and Supports (LTSS). Once the eligible Enrollee count by enrollment status is determined for the contract, the blended LTSS rate will remain in effect through the contract period.

Transition Services - The benefit limit of $2,000 was recommended by Federal partners and validated by an informal cost analysis conducted in 2013. The analysis included sample shopping at multiple retailers to procure essential household furnishings, appliances, and supplies. In addition, Idaho chose to align the $2,000 benefit limit to several other states with approved Transition Services benefits (Colorado, Georgia, Ohio, and Tennessee). The analysis results concluded that this is a reasonable amount. To ensure that there are enough providers to render Transition Services, the State regularly reaches out to existing providers and agencies to raise interest and participation in Transition Management training to increase the provider pool. The participant-directed rate methodology does not differ from the methodology utilized when the service is provider-managed.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

For services provided on a Fee For Service (FFS) basis, provider billing flows directly from the provider to the State's claim payment system. Health PAS Administrator (QNXT) is Idaho's Management Information System (MMIS).

Providers for participants enrolled in the MMCP or Idaho Medicaid Plus bill the MCE (or the MCE's subcontractor, if applicable) for all services rendered.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The following are the processes employed by the State to validate provider billing to produce the claims for FFP:

1. All Medicaid claims for waiver services are processed through the States Medicaid Management Information System (MMIS). The MMIS is managed and monitored through the Division of Medicaid.

2. Participant eligibility is determined by the Division of Welfare. Once eligibility is determined, the participant's information and eligibility is electronically transmitted to the MMIS from the Idaho Benefit Eligibility System (IBES). Claims are edited against the eligibility file in the MMIS to ensure that claims are paid for Medicaid-eligible participants only.

3. Prior authorization of Medicaid reimbursable services on the approved plan of care is entered into the MMIS by the Medicaid staff.

4. Explanation of Medicaid Benefits are generated and sent to a sampling of participants receiving services to verify that the services were provided. All records are maintained by the MMIS and are available for review during post-payment audits. These records include: all claims submitted either electronically or on paper, all remittance and status reports which accompany provider payments; and all adjustment request forms.

The MCE shall submit deliverables in accordance with established timelines and encounter data to the Department's Medicaid Management Information System (MMIS) contractor. Per 42 CFR § 438.60 no supplemental payments shall be made to any network provider outside of the contract for services provided.

The Department will pay the MCE for services on a monthly basis in accordance with requirements for managed care organizations specified in 42 CFR § 438. IDHW will make a capitation payment based on this number on or before the tenth (10th) business day of the month. The capitation payment will include payment or adjustments for participants whose plan eligibility status has been determined retroactively by the IDHW. In the case of PMPM overpayments to the MCE, the Department will provide a separate overpayment bill.

The Department will provide, and the MCE shall accept an 820 Payroll Deducted and Other Group Premium Payment for Insurance Products EDI transaction. The MCE shall create an error report from the 820 Payment Order/Remittance Advice EDI transmission in order to reconcile any discrepancies identified. The MCE shall review the error report against its own records and transmit an 820 Payment Order/Remittance Advice EDI transmission with corrected participant enrollment and disenrollment information. The MCE shall enroll and disenroll participants in the current month or future months when the MCE submits the 820 Payment Order/Remittance Advice EDI transmission to the Department. No retroactive enrollment or disenrollment will be accepted by the Department unless the Department agrees to an exception to retroactive enrollment or disenrollment on a case by case basis. The MCE shall review the report against its own records and report any inconsistencies or errors to the Department for review, confirmation, and reconciliation.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- (●) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ( ) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

- ( ) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of***

the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- (●) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ( ) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ( ) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ( ) ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have

free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

◉ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Medicare Medicaid Coordinated Plan (MMCP) - 1915(a)(c) authority

a) The IDHW contracts with any willing and qualified managed care entity that can meet the contractual obligations of the MMCP scope of work.
b) The geographic area served will be following 30 counties: Ada, Adams, Bannock, Benewah, Bingham, Boise, Bonner, Bonneville, Boundary, Cassia, Canyon, Clark, Elmore, Fremont, Gem, Gooding, Jefferson, Jerome, Kootenai, Latah, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, Shoshone, Twin Falls, Washington, and Valley.
c) Covered services will include all Medicaid services the participants are eligible for, except for the following services: Developmental Disabilities Waiver services, Developmental Disabilities 1915(i) State Plan services, dental services, and non-emergency medical transportation, which will continue to be offered via Medicaid fee-for-service.
d) Capitated payments to the MCE are processed through the Department's MMIS system and are sent to the MCE on a monthly basis.

Idaho Medicaid Plus - 1915(b)/(c) authority
This program is administered in counties in which there are two or more participating health plans. The types of health plans (MCOs) and how payments are made are the same for
both the existing 1915(a)/(c) program (MMCP) and the 1915(b)/(c) program (IMPlus).

a) The IDHW contracts with any willing and qualified managed care entity that can meet the contractual obligations of the Idaho Medicaid Plus scope of work.
b) The geographic area served will be following counties: Ada, Bannock, Bingham, Boise, Bonner, Bonneville, Canyon, Cassia, Elmore, Fremont, Gem, Jefferson, Kootenai, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power and Twin Falls.
c) Covered services will include all Medicaid services the participants are eligible for, except for the following services: Developmental Disabilities Waiver services, Developmental Disabilities 1915(i) State Plan services, dental services, and non-emergency medical transportation, which will continue to be offered via Medicaid fee-for-service.
d) Capitated payments to the MCE are processed through the Department's MMIS system and are sent to the MCE on a monthly basis.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver***

and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***not selected***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home***

of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The following is the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

1. Payment for room and board in residential settings is excluded from Medicaid payment. The room and board allowance in a residential setting is the responsibility of the participant (and/or family or legal representative as appropriate), and is paid to the provider directly on a monthly basis.

2. The room and board allowance is not used to determine eligibility for Medicaid. It is not used to determine eligibility for the basic monthly allowance or the amount of the basic monthly allowance. Further, the room and board allowance is not the basic needs allowance used to calculate/figure client participation.

** Room and board is a living arrangement where the participant purchases lodging (room) and meals (board) from a person he lives with who is not his parent, child, or sibling. As of January 1, 2012, the budgeted room and board allowance is six hundred ninety-three dollars ($693). The Room and Board allowance will be adjusted annually by eighty percent (80%) of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The room and board allowance increase will be rounded up to the next dollar.*

** A participant living in a Residential Care or Assisted Living Facility (RALF), in accordance with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho", or a Certified Family Home (CFH), in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes", is budgeted a basic monthly allowance. This basic allowance will be adjusted annually by twenty percent (20%) of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The basic allowance increase will be rounded down to the nearest dollar.*

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	7440.47	9674.00	17114.47	68174.00	8270.00	76444.00	59329.53
2	6865.66	9754.00	16619.66	70067.00	8684.00	78751.00	62131.34
3	8219.62	9834.00	18053.62	71961.00	9118.00	81079.00	63025.38
4	8242.76	9914.00	18156.76	73854.00	9574.00	83428.00	65271.24
5	8240.04	9994.00	18234.04	75747.00	10053.00	85800.00	67565.96

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	11485	11485
Year 2	11944	11944
Year 3	12422	12422

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 4	12919	12919
Year 5	13436	13436

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

To estimate the waiver length of stay, the A&D waiver CMS 372 reports for the previous three years were used. Days are limited to 365.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Historical waiver expenditure data and user data from the 372 reports were used to assist in projecting forward the estimate for the five-year waiver period. For waiver years 3-5, enrollment data procured for MMCP and Idaho Medicaid Plus for the prior year was used to reallocate population numbers between these two Managed Care Plans according to the percentages of actual dual eligibles who voluntarily enrolled in MMCP versus those who were mandatorily enrolled in Idaho Medicaid Plus. Additionally, percentages were adjusted to incorporate the populations in the new regions being served in each new waiver year.

The estimated number of users of each service (with the exception of Transition Services) was calculated by reviewing the number of users of each service on the 372 report and increasing that number at the same rate that the overall number of waiver participants is expected to increase during the five-year waiver period.

The MMIS was used to derive the historical number of units per user under Fee For Service. Estimated units per user were held constant through the five years of the waiver renewal. The same methodology was used to project number of units per user under MMCP and IMPlus for waiver years 3-5, with the assumption being that the Duals population reflects the same patterns as the FFS population. The State is actively working with the health plans to collect and validate utilization pattern data. The State intends to update the usage patterns accordingly for upcoming waiver years 4-5 by 9/30/20 to account for any necessary adjustments resulting from data provided by the health plans regarding variations identified in the MMCP and IMPlus populations.

The starting cost per unit was derived from the current A & D Fee Schedule. The cost per unit was held constant through the five years of the waiver renewal as the historical changes in reimbursement rates did not result in a predictable pattern to forecast. The waiver will be amended in the event that cost per unit fluctuates over time.

For PERS and Skilled Nursing: For waiver years 3-5, there are new service categories in the PERS and Skilled Nursing service categories. These new categories were necessary to accurately capture the case mix of population and cost per service, as in waiver years 1 and 2, the categories were aggregate values captured in the capitation rate for each of these related services and under each of the Dual Plans.
• For PERS: The categories of "Personal Emergency Response System MMCP" and "Personal Emergency Response System Idaho Medicaid Plus" now each reflect only the case mix and cost for PERS monthly rent, while "PERS 1st Month Rent MMCP" and "PERS 1st Month Rent IMPlus" captures the install rate and 1st month's rent for each these plans. Data provided in waiver years 1 and 2 reflects the aggregate values.
• For Skilled Nursing: The categories of "Skilled Nursing MMCP" and "Skilled Nursing Idaho Medicaid Plus" were broken out to reflect actual case mix between RN, LPN, and Nursing Supervisory Visits for each plan. These new categories replace the categories used in waiver years 1 and 2 as the data in those years reflects the aggregate values of these three components of Skilled Nursing.

For Transition Services: Historical data gathered during the Idaho Home Choice Money Follows the Program (IHCMFP) Demonstration Grant from 2011 through 2017 was used to assist in projecting forward the estimate for the remainder of the five-year waiver period. The estimated number of users of Transition Services was calculated by reviewing the number of users of this service as collected and reported by the IHCMFP Program Manager and increasing that number at the same rate that the overall number of waiver participants is expected to increase during that same period. The average cost per unit for the transition expenses was based on the average utilization per user under the IHCMFP.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Historical Medicaid expenditures for A & D waiver participants from the internal MMIS system were reviewed and projected forward over the five-year estimate period, based on the historical trend.

Factor D' does not include the costs of prescription drugs.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Estimates were derived from actual data available in the internal MMIS system, and then projected forward over the five-year estimate period, based on the historical trend.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Estimates were derived from actual data available in the internal MMIS system, and then projected forward over the five-year estimate period, based on the historical trend.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health	
Day Habilitation	
Homemaker	
Residential Habilitation	
Respite	
Supported Employment	
Attendant Care	
Adult Residential Care	
Chore Service	
Companion Services	
Consultation	
Environmental Accessibility Adaptations	
Home Delivered Meals	
Non-medical Transportation	
Personal Emergency Response System	
Skilled Nursing	
Specialized Medical Equipment and Supplies	
Transition Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**181575.96**
Adult Day Health MMCP	☒	Per Member Per Month	8	12.00	0.01	**0.96**	
Adult Day Health	☐	Per 15 Minute Unit	90	1345.00	1.50	**181575.00**	
Adult Day Health Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	**0.00**	
Day Habilitation Total:							**27361.20**
Day Habilitation	☐	Per 15 Minute Unit	2	3020.00	4.53	**27361.20**	
Day Habilitation MMCP	☒	Per Member Per Month	0	12.00	0.01	**0.00**	
Day Habilitation Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	**0.00**	
Homemaker Total:							**19656337.04**
Homemaker MMCP	☒	Per Member Per Month	190	12.00	0.01	**22.80**	
Homemaker	☐	Per 15 Minute Unit	6416	764.00	4.01	**19656314.24**	
Homemaker Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	**0.00**	
Residential Habilitation Total:							**2785356.24**
Residential Habilitation	☐	Per Diem	24	350.00	331.59	**2785356.00**	
Residential Habilitation MMCP	☒	Per Member Per Month	2	12.00	0.01	**0.24**	
Residential Habilitation Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	**0.00**	
Respite Total:							**129020.04**
Respite	☐	Per 15 Minute Unit	92	371.00	3.78	**129018.96**	
Respite MMCP	☒	Per Member Per Month	9	12.00	0.01	**1.08**	
Respite Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	**0.00**	
Supported							**37884.12**

GRAND TOTAL:	**85453742.53**
Total: Services included in capitation:	218.16
Total: Services not included in capitation:	85453524.37
Total Estimated Unduplicated Participants:	**11485**
Factor D (Divide total by number of participants):	**7440.47**
Services included in capitation:	0.02
Services not included in capitation:	7440.45
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Total:							
Supported Employment MMCP	☒	Per Member Per Month	1	12.00	0.01	0.12	
Supported Employment	☐	Per 15 Minute Unit	8	902.00	5.25	37884.00	
Supported Employment Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	0.00	
Attendant Care Total:							9671049.51
Attendant Care MMCP	☒	Per Member Per Month	173	12.00	0.01	20.76	
Attendant Care	☐	Per 15 Minute Unit	1845	1205.00	4.35	9671028.75	
Attendant Care Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	0.00	
Adult Residential Care Total:							45118296.16
Adult Residential Care	☐	Per Diem	4913	248.00	37.03	45118240.72	
Adult Residential Care MMCP	☒	Per Member Per Month	462	12.00	0.01	55.44	
Adult Residential Care Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	0.00	
Chore Service Total:							185206.60
Chore Services	☐	Per 15 Minute Unit	332	152.00	3.67	185202.88	
Chore Service MMCP	☒	Per Member Per Month	31	12.00	0.01	3.72	
Chore Service Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	0.00	
Companion Services Total:							3426429.39
Companion Services MMCP	☒	Per Member Per Month	48	12.00	0.01	5.76	
Companion Services	☐	Per 15 Minute Unit	511	1689.00	3.97	3426423.63	
Companion Services Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	0.00	

GRAND TOTAL:	85453742.53
Total: Services included in capitation:	218.16
Total: Services not included in capitation:	85453524.37
Total Estimated Unduplicated Participants:	11485
Factor D (Divide total by number of participants):	7440.47
Services included in capitation:	0.02
Services not included in capitation:	7440.45
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultation Total:							**4854.48**
Consultation MMCP	☒	Per Member Per Month	11	12.00	0.01	**1.32**	
Consultation	☐	Per 15 Minute Unit	122	5.20	7.65	**4853.16**	
Consultation Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations Total:							**85519.92**
Environmental Accessibility Adaptations	☐	Per Job	24	1.00	3563.32	**85519.68**	
Environmental Accessibility Adaptations MMCP	☒	Per Member Per Month	2	12.00	0.01	**0.24**	
Environmental Accessibility Adaptations Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	**0.00**	
Home Delivered Meals Total:							**2301965.46**
Home Delivered Meals	☐	Per Meal	2019	218.00	5.23	**2301942.66**	
Home Delivered Meals MMCP	☒	Per Member Per Month	190	12.00	0.01	**22.80**	
Home Delivered Meals Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	**0.00**	
Non-medical Transportation Total:							**227682.40**
Non-medical Transportation MMCP	☒	Per Member Per Month	88	12.00	0.01	**10.56**	
Non-medical Transportation	☐	Per Mile	934	554.00	0.44	**227671.84**	
Non-medical Transportation Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	**0.00**	
Personal Emergency Response System Total:							**503791.67**
Personal	☐					**19058.15**	

GRAND TOTAL:	**85453742.53**
Total: Services included in capitation:	218.16
Total: Services not included in capitation:	85453524.37
Total Estimated Unduplicated Participants:	**11485**
Factor D (Divide total by number of participants):	**7440.47**
Services included in capitation:	0.02
Services not included in capitation:	7440.45
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Response System 1st Month Rent		Per Month (+	335	1.00	56.89		
Personal Emergency Response System Monthly Rent	☐	Per Month	1592	9.00	33.83	484716.24	
Personal Emergency Response System MMCP	☒	Per Member Per Month	144	12.00	0.01	17.28	
Personal Emergency Response System Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	0.00	
PERS 1st Month Rent MMCP	☐	Per Month (+ Install)	0	0.00	0.01	0.00	
PERS 1st Month Rent IMPlus	☐	Per Month (+ Install)	0	0.00	0.01	0.00	
Skilled Nursing Total:							1039564.52
RN Nursing Services	☐	Per 15 Minute Unit	131	33.00	10.19	44051.37	
LPN Nursing Services	☐	Per 15 Minute Unit	111	619.00	7.31	502262.79	
Skilled Nursing MMCP	☒	Per Member Per Month	453	12.00	0.01	54.36	
Nursing Supervisory Visits	☐	Per Visit	4840	2.00	50.95	493196.00	
Skilled Nursing Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	0.00	
RN Nursing Services MMCP	☐	Per 15 Minute Unit	0	0.00	0.01	0.00	
RN Nursing Services IMPlus	☐	Per 15 Minute Unit	0	0.00	0.01	0.00	
Nursing Supervisory Visits MMCP	☐	Per Visit	0	0.00	0.01	0.00	
Nursing Supervisory Visits IMPlus	☐	Per Visit	0	0.00	0.01	0.00	
LPN Nursing Services MMCP	☐	Per 15 Minute Unit	0	0.00	0.01	0.00	

GRAND TOTAL:	85453742.53
Total: Services included in capitation:	218.16
Total: Services not included in capitation:	85453524.37
Total Estimated Unduplicated Participants:	11485
Factor D (Divide total by number of participants):	7440.47
Services included in capitation:	0.02
Services not included in capitation:	7440.45
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
LPN Nursing Services IMPlus	☐	Per 15 Minute Unit	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies Total:							71847.82
Specialized Medical Equipment and Supplies MMCP	☒	Per Member Per Month	6	12.00	0.01	0.72	
Specialized Medical Equipment and Supplies	☐	Per Piece of Equipment	65	2.00	552.67	71847.10	
Specialized Medical Equipment and Supplies Idaho Medicaid Plus	☒	Per Member Per Month	0	0.00	0.01	0.00	
Transition Services Total:							0.00
Transition Services	☐	Per Transition	0	1.00	834.00	0.00	
Transition Services MMCP	☒	Per Member Per	0	1.00	0.01	0.00	
Transition Services Idaho Medicaid Plus	☒	Per Member Per	0	1.00	0.01	0.00	

GRAND TOTAL:	85453742.53
Total: Services included in capitation:	218.16
Total: Services not included in capitation:	85453524.37
Total Estimated Unduplicated Participants:	11485
Factor D (Divide total by number of participants):	7440.47
Services included in capitation:	0.02
Services not included in capitation:	7440.45
Average Length of Stay on the Waiver:	285

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**169472.16**
Adult Day Health MMCP	☒	Per Member Per Month	9	12.00	0.01	**1.08**	
Adult Day Health	☐	Per 15 Minute Unit	84	1345.00	1.50	**169470.00**	
Adult Day Health Idaho Medicaid Plus	☒	Per Member Per Month	9	12.00	0.01	**1.08**	
Day Habilitation Total:							**27361.20**
Day Habilitation	☐	Per 15 Minute Unit	2	3020.00	4.53	**27361.20**	
Day Habilitation MMCP	☒	Per Member Per Month	0	12.00	0.01	**0.00**	
Day Habilitation Idaho Medicaid Plus	☒	Per Member Per Month	0	12.00	0.01	**0.00**	
Homemaker Total:							**19088613.12**
Homemaker MMCP	☒	Per Member Per Month	197	12.00	0.01	**23.64**	
Homemaker	☐	Per 15 Minute Unit	6006	764.00	4.16	**19088509.44**	
Homemaker Idaho Medicaid Plus	☒	Per Member Per Month	667	12.00	0.01	**80.04**	
Residential Habilitation Total:							**3371445.60**
Residential Habilitation	☐	Per Diem	22	350.00	437.85	**3371445.00**	
Residential Habilitation MMCP	☒	Per Member Per Month	2	12.00	0.01	**0.24**	
Residential Habilitation Idaho Medicaid Plus	☒	Per Member Per Month	3	12.00	0.01	**0.36**	
Respite Total:							**132731.24**
Respite	☐	Per 15 Minute Unit	86	371.00	4.16	**132728.96**	
Respite MMCP	☒	Per Member Per Month	9	12.00	0.01	**1.08**	
Respite Idaho Medicaid Plus	☒	Per Member Per Month	10	12.00	0.01	**1.20**	
Supported							**33148.74**

GRAND TOTAL:	**82003413.33**
Total: Services included in capitation:	499.62
Total: Services not included in capitation:	82002913.71
Total Estimated Unduplicated Participants:	**11944**
Factor D (Divide total by number of participants):	**6865.66**
Services included in capitation:	0.04
Services not included in capitation:	6865.62
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Total:							
Supported Employment MMCP	☒	Per Member Per Month	1	12.00	0.01	0.12	
Supported Employment	☐	Per 15 Minute Unit	7	902.00	5.25	33148.50	
Supported Employment Idaho Medicaid Plus	☒	Per Member Per Month	1	12.00	0.01	0.12	
Attendant Care Total:							9349279.20
Attendant Care MMCP	☒	Per Member Per Month	180	12.00	0.01	21.60	
Attendant Care	☐	Per 15 Minute Unit	1728	1205.00	4.49	9349257.60	
Attendant Care Idaho Medicaid Plus	☒	Per Member Per Month	191	0.00	0.01	0.00	
Adult Residential Care Total:							42234759.36
Adult Residential Care	☐	Per Diem	4599	248.00	37.03	42234640.56	
Adult Residential Care MMCP	☒	Per Member Per Month	480	12.00	0.01	57.60	
Adult Residential Care Idaho Medicaid Plus	☒	Per Member Per Month	510	12.00	0.01	61.20	
Chore Service Total:							188959.24
Chore Services	☐	Per 15 Minute Unit	310	152.00	4.01	188951.20	
Chore Service MMCP	☒	Per Member Per Month	32	12.00	0.01	3.84	
Chore Service Idaho Medicaid Plus	☒	Per Member Per Month	35	12.00	0.01	4.20	
Companion Services Total:							3358555.08
Companion Services MMCP	☒	Per Member Per Month	50	12.00	0.01	6.00	
Companion Services	☐	Per 15 Minute Unit	478	1689.00	4.16	3358542.72	
Companion Services Idaho Medicaid Plus	☒	Per Member Per Month	53	12.00	0.01	6.36	

GRAND TOTAL:	82003413.33
Total: Services included in capitation:	499.62
Total: Services not included in capitation:	82002913.71
Total Estimated Unduplicated Participants:	11944
Factor D (Divide total by number of participants):	6865.66
Services included in capitation:	0.04
Services not included in capitation:	6865.62
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultation Total:							**4537.92**
Consultation MMCP	☒	Per Member Per Month	12	12.00	0.01	**1.44**	
Consultation	☐	Per 15 Minute Unit	114	5.20	7.65	**4534.92**	
Consultation Idaho Medicaid Plus	☐	Per Member Per Month	13	12.00	0.01	**1.56**	
Environmental Accessibility Adaptations Total:							**78393.64**
Environmental Accessibility Adaptations	☐	Per Job	22	1.00	3563.32	**78393.04**	
Environmental Accessibility Adaptations MMCP	☒	Per Member Per Month	2	12.00	0.01	**0.24**	
Environmental Accessibility Adaptations Idaho Medicaid Plus	☒	Per Member Per Month	3	12.00	0.01	**0.36**	
Home Delivered Meals Total:							**2154913.44**
Home Delivered Meals	☐	Per Meal	1890	218.00	5.23	**2154864.60**	
Home Delivered Meals MMCP	☒	Per Member Per Month	197	12.00	0.01	**23.64**	
Home Delivered Meals Idaho Medicaid Plus	☒	Per Member Per Month	210	12.00	0.01	**25.20**	
Non-medical Transportation Total:							**213068.80**
Non-medical Transportation MMCP	☒	Per Member Per Month	91	12.00	0.01	**10.92**	
Non-medical Transportation	☐	Per Mile	874	554.00	0.44	**213046.24**	
Non-medical Transportation Idaho Medicaid Plus	☒	Per Member Per Month	97	12.00	0.01	**11.64**	
Personal Emergency Response System Total:							**473552.83**
Personal	☐					**19854.61**	

GRAND TOTAL:	**82003413.33**
Total: Services included in capitation:	499.62
Total: Services not included in capitation:	82002913.71
Total Estimated Unduplicated Participants:	**11944**
Factor D (Divide total by number of participants):	**6865.66**
Services included in capitation:	0.04
Services not included in capitation:	6865.62
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Response System 1st Month Rent		Per Month (+	349	1.00	56.89		
Personal Emergency Response System Monthly Rent	☐	Per Month	1490	9.00	33.83	453660.30	
Personal Emergency Response System MMCP	☒	Per Member Per Month	150	12.00	0.01	18.00	
Personal Emergency Response System Idaho Medicaid Plus	☒	Per Member Per Month	166	12.00	0.01	19.92	
PERS 1st Month Rent MMCP	☐	Per Month	0	0.00	0.01	0.00	
PERS 1st Month Rent IMPlus	☐	Per Month	0	0.00	0.01	0.00	
Skilled Nursing Total:							1032445.74
RN Nursing Services	☐	Per 15 Minute Unit	136	33.00	10.19	45732.72	
LPN Nursing Services	☐	Per 15 Minute Unit	116	619.00	7.31	524887.24	
Skilled Nursing MMCP	☒	Per Member Per Month	471	12.00	0.01	56.52	
Nursing Supervisory Visits	☐	Per Visit	4531	2.00	50.95	461708.90	
Skilled Nursing Idaho Medicaid Plus	☒	Per Member Per Month	503	12.00	0.01	60.36	
RN Nursing Services MMCP	☐	Per 15 Minute Unit	0	0.00	0.01	0.00	
RN Nursing Services IMPlus	☐	Per 15 Minute Unit	0	0.00	0.01	0.00	
Nursing Supervisory Visits MMCP	☐	Per Visit	0	0.00	0.01	0.00	
Nursing Supervisory Visits IMPlus	☐	Per Visit	0	0.00	0.01	0.00	
LPN Nursing Services MMCP	☐	Per 15 Minute Unit	0	0.00	0.01	0.00	

GRAND TOTAL:	82003413.33
Total: Services included in capitation:	499.62
Total: Services not included in capitation:	82002913.71
Total Estimated Unduplicated Participants:	11944
Factor D (Divide total by number of participants):	6865.66
Services included in capitation:	0.04
Services not included in capitation:	6865.62
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
LPN Nursing Services IMPlus	☐	Per 15 Minute Unit	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies Total:							66321.96
Specialized Medical Equipment and Supplies MMCP	☒	Per Member Per Month	6	12.00	0.01	0.72	
Specialized Medical Equipment and Supplies	☐	Per Piece of Equipment	60	2.00	552.67	66320.40	
Specialized Medical Equipment and Supplies Idaho Medicaid Plus	☒	Per Member Per Month	7	12.00	0.01	0.84	
Transition Services Total:							25854.06
Transition Services	☐	Per Transition	31	1.00	834.00	25854.00	
Transition Services MMCP	☒	Per Member Per	3	1.00	0.01	0.03	
Transition Services Idaho Medicaid Plus	☒	Per Member Per	3	1.00	0.01	0.03	

GRAND TOTAL:	82003413.33
Total: Services included in capitation:	499.62
Total: Services not included in capitation:	82002913.71
Total Estimated Unduplicated Participants:	11944
Factor D (Divide total by number of participants):	6865.66
Services included in capitation:	0.04
Services not included in capitation:	6865.62
Average Length of Stay on the Waiver:	285

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**213855.00**
Adult Day Health MMCP	☐	Per 15 Minute Unit	37	1345.00	1.50	**74647.50**	
Adult Day Health	☐	Per 15 Minute Unit	24	1345.00	1.50	**48420.00**	
Adult Day Health Idaho Medicaid Plus	☐	Per 15 Minute Unit	45	1345.00	1.50	**90787.50**	
Day Habilitation Total:							**27361.20**
Day Habilitation	☐	Per 15 Minute Unit	0	3020.00	4.53	**0.00**	
Day Habilitation MMCP	☐	Per 15 Minute Unit	1	3020.00	4.53	**13680.60**	
Day Habilitation Idaho Medicaid Plus	☐	Per 15 Minute Unit	1	3020.00	4.53	**13680.60**	
Homemaker Total:							**22705346.56**
Homemaker MMCP	☐	Per 15 Minute Unit	2475	764.00	4.16	**7866144.00**	
Homemaker	☐	Per 15 Minute Unit	1610	764.00	4.16	**5116966.40**	
Homemaker Idaho Medicaid Plus	☐	Per 15 Minute Unit	3059	764.00	4.16	**9722236.16**	
Residential Habilitation Total:							**4290930.00**
Residential Habilitation	☐	Per Diem	6	350.00	437.85	**919485.00**	
Residential Habilitation MMCP	☐	Per Diem	10	350.00	437.85	**1532475.00**	
Residential Habilitation Idaho Medicaid Plus	☐	Per Diem	12	350.00	437.85	**1838970.00**	
Respite Total:							**169769.60**
Respite	☐	Per 15 Minute Unit	25	371.00	4.16	**38584.00**	
Respite MMCP	☐	Per 15 Minute Unit	38	371.00	4.16	**58647.68**	
Respite Idaho Medicaid Plus	☐	Per 15 Minute Unit	47	371.00	4.16	**72537.92**	
Supported							**42619.50**

GRAND TOTAL:	**102104151.93**
Total: Services included in capitation:	
Total: Services not included in capitation:	102104151.93
Total Estimated Unduplicated Participants:	**12422**
Factor D (Divide total by number of participants):	**8219.62**
Services included in capitation:	
Services not included in capitation:	8219.62
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Total:							
Supported Employment MMCP	☐	Per 15 Minute Unit	3	902.00	5.25	14206.50	
Supported Employment	☐	Per 15 Minute Unit	2	902.00	5.25	9471.00	
Supported Employment Idaho Medicaid Plus	☐	Per 15 Minute Unit	4	902.00	5.25	18942.00	
Attendant Care Total:							11811012.35
Attendant Care MMCP	☐	Per 15 Minute Unit	756	1205.00	4.49	4090300.20	
Attendant Care	☐	Per 15 Minute Unit	492	1205.00	4.49	2661941.40	
Attendant Care Idaho Medicaid Plus	☐	Per 15 Minute Unit	935	1205.00	4.49	5058770.75	
Adult Residential Care Total:							53383336.72
Adult Residential Care	☐	Per Diem	1310	248.00	37.03	12030306.40	
Adult Residential Care MMCP	☐	Per Diem	2014	248.00	37.03	18495448.16	
Adult Residential Care Idaho Medicaid Plus	☐	Per Diem	2489	248.00	37.03	22857582.16	
Chore Service Total:							238931.84
Chore Services	☐	Per 15 Minute Unit	88	152.00	4.01	53637.76	
Chore Service MMCP	☐	Per 15 Minute Unit	136	152.00	4.01	82894.72	
Chore Service Idaho Medicaid Plus	☐	Per 15 Minute Unit	168	152.00	4.01	102399.36	
Companion Services Total:							4117376.64
Companion Services MMCP	☐	Per 15 Minute Unit	201	1689.00	4.16	1412274.24	
Companion Services	☐	Per 15 Minute Unit	136	1689.00	4.16	955568.64	
Companion Services Idaho Medicaid Plus	☐	Per 15 Minute Unit	249	1689.00	4.16	1749533.76	

GRAND TOTAL:	102104151.93
Total: Services included in capitation:	
Total: Services not included in capitation:	102104151.93
Total Estimated Unduplicated Participants:	12422
Factor D (Divide total by number of participants):	8219.62
Services included in capitation:	
Services not included in capitation:	8219.62
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultation Total:							**5728.32**
Consultation MMCP	☐	Per 15 Minute Unit	50	5.20	7.65	**1989.00**	
Consultation	☐	Per 15 Minute Unit	32	5.20	7.65	**1272.96**	
Consultation Idaho Medicaid Plus	☐	Per 15 Minute Unit	62	5.20	7.65	**2466.36**	
Environmental Accessibility Adaptations Total:							**99772.96**
Environmental Accessibility Adaptations	☐	Per Job	6	1.00	3563.32	**21379.92**	
Environmental Accessibility Adaptations MMCP	☐	Per Job	10	1.00	3563.32	**35633.20**	
Environmental Accessibility Adaptations Idaho Medicaid Plus	☐	Per Job	12	1.00	3563.32	**42759.84**	
Home Delivered Meals Total:							**2723794.46**
Home Delivered Meals	☐	Per Meal	538	218.00	5.23	**613395.32**	
Home Delivered Meals MMCP	☐	Per Meal	828	218.00	5.23	**944035.92**	
Home Delivered Meals Idaho Medicaid Plus	☐	Per Meal	1023	218.00	5.23	**1166363.22**	
Non-medical Transportation Total:							**269354.80**
Non-medical Transportation MMCP	☐	Per Mile	383	554.00	0.44	**93360.08**	
Non-medical Transportation	☐	Per Mile	249	554.00	0.44	**60696.24**	
Non-medical Transportation Idaho Medicaid Plus	☐	Per Mile	473	554.00	0.44	**115298.48**	
Personal Emergency Response System Total:							**592445.73**
Personal	☐					**4664.98**	

GRAND TOTAL:	**102104151.93**
Total: Services included in capitation:	
Total: Services not included in capitation:	102104151.93
Total Estimated Unduplicated Participants:	**12422**
Factor D (Divide total by number of participants):	**8219.62**
Services included in capitation:	
Services not included in capitation:	8219.62
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Response System 1st Month Rent		Per Month (+ Install)	82	1.00	56.89		
Personal Emergency Response System Monthly Rent	☐	Per Month	423	9.00	33.83	128790.81	
Personal Emergency Response System MMCP	☐	Per Month	651	9.00	33.83	198209.97	
Personal Emergency Response System Idaho Medicaid Plus	☐	Per Month	804	9.00	33.83	244793.88	
PERS 1st Month Rent MMCP	☐	Per Month (+ Install)	126	1.00	56.89	7168.14	
PERS 1st Month Rent IMPlus	☐	Per Month (+ Install)	155	1.00	56.89	8817.95	
Skilled Nursing Total:							1291251.75
RN Nursing Services	☐	Per 15 Minute Unit	38	33.00	10.19	12778.26	
LPN Nursing Services	☐	Per 15 Minute Unit	33	619.00	7.31	149321.37	
Skilled Nursing MMCP	☐	Per Member Per Month	0	0.00	0.01	0.00	
Nursing Supervisory Visits	☐	Per Visit	1279	2.00	50.95	130330.10	
Skilled Nursing Idaho Medicaid Plus	☐	Per Member Per Month	0	0.00	0.01	0.00	
RN Nursing Services MMCP	☐	Per 15 Minute Unit	59	33.00	10.19	19839.93	
RN Nursing Services IMPlus	☐	Per 15 Minute Unit	73	33.00	10.19	24547.71	
Nursing Supervisory Visits MMCP	☐	Per Visit	1965	2.00	50.95	200233.50	
Nursing Supervisory Visits IMPlus	☐	Per Visit	2428	2.00	50.95	247413.20	
LPN Nursing Services MMCP	☐	Per 15 Minute Unit	50	619.00	7.31	226244.50	

GRAND TOTAL:	102104151.93
Total: Services included in capitation:	
Total: Services not included in capitation:	102104151.93
Total Estimated Unduplicated Participants:	12422
Factor D (Divide total by number of participants):	8219.62
Services included in capitation:	
Services not included in capitation:	8219.62
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
LPN Nursing Services IMPlus	☐	Per 15 Minute Unit	62	619.00	7.31	280543.18	
Specialized Medical Equipment and Supplies Total:							82900.50
Specialized Medical Equipment and Supplies MMCP	☐	Per Piece of Equipment	26	2.00	552.67	28738.84	
Specialized Medical Equipment and Supplies	☐	Per Piece of Equipment	17	2.00	552.67	18790.78	
Specialized Medical Equipment and Supplies Idaho Medicaid Plus	☐	Per Piece of Equipment	32	2.00	552.67	35370.88	
Transition Services Total:							38364.00
Transition Services	☐	Per Transition	12	1.00	834.00	10008.00	
Transition Services MMCP	☐	Per Transition	17	1.00	834.00	14178.00	
Transition Services Idaho Medicaid Plus	☐	Per Transition	17	1.00	834.00	14178.00	

GRAND TOTAL:	102104151.93
Total: Services included in capitation:	
Total: Services not included in capitation:	102104151.93
Total Estimated Unduplicated Participants:	12422
Factor D (Divide total by number of participants):	8219.62
Services included in capitation:	
Services not included in capitation:	8219.62
Average Length of Stay on the Waiver:	285

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**217890.00**
Adult Day Health MMCP	☐	Per 15 Minute Unit	37	1345.00	1.50	**74647.50**	
Adult Day Health	☐	Per 15 Minute Unit	24	1345.00	1.50	**48420.00**	
Adult Day Health Idaho Medicaid Plus	☐	Per 15 Minute Unit	47	1345.00	1.50	**94822.50**	
Day Habilitation Total:							**41041.80**
Day Habilitation	☐	Per 15 Minute Unit	1	3020.00	4.53	**13680.60**	
Day Habilitation MMCP	☐	Per 15 Minute Unit	1	3020.00	4.53	**13680.60**	
Day Habilitation Idaho Medicaid Plus	☐	Per 15 Minute Unit	1	3020.00	4.53	**13680.60**	
Homemaker Total:							**23617501.44**
Homemaker MMCP	☐	Per 15 Minute Unit	2574	764.00	4.16	**8180789.76**	
Homemaker	☐	Per 15 Minute Unit	1675	764.00	4.16	**5323552.00**	
Homemaker Idaho Medicaid Plus	☐	Per 15 Minute Unit	3182	764.00	4.16	**10113159.68**	
Residential Habilitation Total:							**4597425.00**
Residential Habilitation	☐	Per Diem	7	350.00	437.85	**1072732.50**	
Residential Habilitation MMCP	☐	Per Diem	10	350.00	437.85	**1532475.00**	
Residential Habilitation Idaho Medicaid Plus	☐	Per Diem	13	350.00	437.85	**1992217.50**	
Respite Total:							**175943.04**
Respite	☐	Per 15 Minute Unit	26	371.00	4.16	**40127.36**	
Respite MMCP	☐	Per 15 Minute Unit	39	371.00	4.16	**60191.04**	
Respite Idaho Medicaid Plus	☐	Per 15 Minute Unit	49	371.00	4.16	**75624.64**	
Supported							**47355.00**

GRAND TOTAL:	**106488238.73**
Total: Services included in capitation:	
Total: Services not included in capitation:	106488238.73
Total Estimated Unduplicated Participants:	**12919**
Factor D (Divide total by number of participants):	**8242.76**
Services included in capitation:	
Services not included in capitation:	8242.76
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Total:							
Supported Employment MMCP	☐	Per 15 Minute Unit	2	902.00	5.25	9471.00	
Supported Employment	☐	Per 15 Minute Unit	4	902.00	5.25	18942.00	
Supported Employment Idaho Medicaid Plus	☐	Per 15 Minute Unit	4	902.00	5.25	18942.00	
Attendant Care Total:							12281721.50
Attendant Care MMCP	☐	Per 15 Minute Unit	786	1205.00	4.49	4252613.70	
Attendant Care	☐	Per 15 Minute Unit	512	1205.00	4.49	2770150.40	
Attendant Care Idaho Medicaid Plus	☐	Per 15 Minute Unit	972	1205.00	4.49	5258957.40	
Adult Residential Care Total:							55523078.24
Adult Residential Care	☐	Per Diem	1363	248.00	37.03	12517028.72	
Adult Residential Care MMCP	☐	Per Diem	2094	248.00	37.03	19230123.36	
Adult Residential Care Idaho Medicaid Plus	☐	Per Diem	2589	248.00	37.03	23775926.16	
Chore Service Total:							248684.16
Chore Services	☐	Per 15 Minute Unit	92	152.00	4.01	56075.84	
Chore Service MMCP	☐	Per 15 Minute Unit	141	152.00	4.01	85942.32	
Chore Service Idaho Medicaid Plus	☐	Per 15 Minute Unit	175	152.00	4.01	106666.00	
Companion Services Total:							4419504.96
Companion Services MMCP	☐	Per 15 Minute Unit	218	1689.00	4.16	1531720.32	
Companion Services	☐	Per 15 Minute Unit	142	1689.00	4.16	997726.08	
Companion Services Idaho Medicaid Plus	☐	Per 15 Minute Unit	269	1689.00	4.16	1890058.56	

GRAND TOTAL:	106488238.73
Total: Services included in capitation:	
Total: Services not included in capitation:	106488238.73
Total Estimated Unduplicated Participants:	12919
Factor D (Divide total by number of participants):	8242.76
Services included in capitation:	
Services not included in capitation:	8242.76
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultation Total:							**5967.00**
Consultation MMCP	☐	Per 15 Minute Unit	52	5.20	7.65	**2068.56**	
Consultation	☐	Per 15 Minute Unit	34	5.20	7.65	**1352.52**	
Consultation Idaho Medicaid Plus	☐	Per 15 Minute Unit	64	5.20	7.65	**2545.92**	
Environmental Accessibility Adaptations Total:							**106899.60**
Environmental Accessibility Adaptations	☐	Per Job	7	1.00	3563.32	**24943.24**	
Environmental Accessibility Adaptations MMCP	☐	Per Job	10	1.00	3563.32	**35633.20**	
Environmental Accessibility Adaptations Idaho Medicaid Plus	☐	Per Job	13	1.00	3563.32	**46323.16**	
Home Delivered Meals Total:							**2832107.76**
Home Delivered Meals	☐	Per Meal	560	218.00	5.23	**638478.40**	
Home Delivered Meals MMCP	☐	Per Meal	860	218.00	5.23	**980520.40**	
Home Delivered Meals Idaho Medicaid Plus	☐	Per Meal	1064	218.00	5.23	**1213108.96**	
Non-medical Transportation Total:							**280080.24**
Non-medical Transportation MMCP	☐	Per Mile	398	554.00	0.44	**97016.48**	
Non-medical Transportation	☐	Per Mile	259	554.00	0.44	**63133.84**	
Non-medical Transportation Idaho Medicaid Plus	☐	Per Mile	492	554.00	0.44	**119929.92**	
Personal Emergency Response System Total:							**621557.90**
Personal	☐					**4835.65**	

GRAND TOTAL:	**106488238.73**
Total: Services included in capitation:	
Total: Services not included in capitation:	106488238.73
Total Estimated Unduplicated Participants:	**12919**
Factor D (Divide total by number of participants):	**8242.76**
Services included in capitation:	
Services not included in capitation:	8242.76
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Response System 1st Month Rent		Per Month (+	85	1.00	56.89		
Personal Emergency Response System Monthly Rent	☐	Per Month	444	9.00	33.83	135184.68	
Personal Emergency Response System MMCP	☐	Per Month	683	9.00	33.83	207953.01	
Personal Emergency Response System Idaho Medicaid Plus	☐	Per Month	844	9.00	33.83	256972.68	
PERS 1st Month Rent MMCP	☐	Per Month (+ Install)	131	1.00	56.89	7452.59	
PERS 1st Month Rent IMPlus	☐	Per Month (+ Install)	161	1.00	56.89	9159.29	
Skilled Nursing Total:							1338851.89
RN Nursing Services	☐	Per 15 Minute Unit	40	33.00	10.19	13450.80	
LPN Nursing Services	☐	Per 15 Minute Unit	34	619.00	7.31	153846.26	
Skilled Nursing MMCP	☐	Per Member Per Month	0	0.00	0.01	0.00	
Nursing Supervisory Visits	☐	Per Visit	1329	2.00	50.95	135425.10	
Skilled Nursing Idaho Medicaid Plus	☐	Per Member Per Month	0	0.00	0.01	0.00	
RN Nursing Services MMCP	☐	Per 15 Minute Unit	61	33.00	10.19	20512.47	
RN Nursing Services IMPlus	☐	Per 15 Minute Unit	76	33.00	10.19	25556.52	
Nursing Supervisory Visits MMCP	☐	Per Visit	2042	2.00	50.95	208079.80	
Nursing Supervisory Visits IMPlus	☐	Per Visit	2523	2.00	50.95	257093.70	
LPN Nursing Services MMCP	☐	Per 15 Minute Unit	52	619.00	7.31	235294.28	

GRAND TOTAL:	106488238.73
Total: Services included in capitation:	
Total: Services not included in capitation:	106488238.73
Total Estimated Unduplicated Participants:	12919
Factor D (Divide total by number of participants):	8242.76
Services included in capitation:	
Services not included in capitation:	8242.76
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
LPN Nursing Services IMPlus	☐	Per 15 Minute Unit	64	619.00	7.31	289592.96	
Specialized Medical Equipment and Supplies Total:							88427.20
Specialized Medical Equipment and Supplies MMCP	☐	Per Piece of Equipment	28	2.00	552.67	30949.52	
Specialized Medical Equipment and Supplies	☐	Per Piece of Equipment	18	2.00	552.67	19896.12	
Specialized Medical Equipment and Supplies Idaho Medicaid Plus	☐	Per Piece of Equipment	34	2.00	552.67	37581.56	
Transition Services Total:							44202.00
Transition Services	☐	Per Transition	12	1.00	834.00	10008.00	
Transition Services MMCP	☐	Per Transition	18	1.00	834.00	15012.00	
Transition Services Idaho Medicaid Plus	☐	Per Transition	23	1.00	834.00	19182.00	

GRAND TOTAL:	106488238.73
Total: Services included in capitation:	
Total: Services not included in capitation:	106488238.73
Total Estimated Unduplicated Participants:	12919
Factor D (Divide total by number of participants):	8242.76
Services included in capitation:	
Services not included in capitation:	8242.76
Average Length of Stay on the Waiver:	285

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**232012.50**
Adult Day Health MMCP	☐	Per 15 Minute Unit	40	1345.00	1.50	**80700.00**	
Adult Day Health	☐	Per 15 Minute Unit	26	1345.00	1.50	**52455.00**	
Adult Day Health Idaho Medicaid Plus	☐	Per 15 Minute Unit	49	1345.00	1.50	**98857.50**	
Day Habilitation Total:							**41041.80**
Day Habilitation	☐	Per 15 Minute Unit	1	3020.00	4.53	**13680.60**	
Day Habilitation MMCP	☐	Per 15 Minute Unit	1	3020.00	4.53	**13680.60**	
Day Habilitation Idaho Medicaid Plus	☐	Per 15 Minute Unit	1	3020.00	4.53	**13680.60**	
Homemaker Total:							**24561438.72**
Homemaker MMCP	☐	Per 15 Minute Unit	2677	764.00	4.16	**8508148.48**	
Homemaker	☐	Per 15 Minute Unit	1742	764.00	4.16	**5536494.08**	
Homemaker Idaho Medicaid Plus	☐	Per 15 Minute Unit	3309	764.00	4.16	**10516796.16**	
Residential Habilitation Total:							**4750672.50**
Residential Habilitation	☐	Per Diem	7	350.00	437.85	**1072732.50**	
Residential Habilitation MMCP	☐	Per Diem	11	350.00	437.85	**1685722.50**	
Residential Habilitation Idaho Medicaid Plus	☐	Per Diem	13	350.00	437.85	**1992217.50**	
Respite Total:							**183659.84**
Respite	☐	Per 15 Minute Unit	27	371.00	4.16	**41670.72**	
Respite MMCP	☐	Per 15 Minute Unit	41	371.00	4.16	**63277.76**	
Respite Idaho Medicaid Plus	☐	Per 15 Minute Unit	51	371.00	4.16	**78711.36**	
Supported							**52090.50**

GRAND TOTAL:	**110713148.08**
Total: Services included in capitation:	
Total: Services not included in capitation:	110713148.08
Total Estimated Unduplicated Participants:	**13436**
Factor D (Divide total by number of participants):	**8240.04**
Services included in capitation:	
Services not included in capitation:	8240.04
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Total:							
Supported Employment MMCP	☐	Per 15 Minute Unit	4	902.00	5.25	18942.00	
Supported Employment	☐	Per 15 Minute Unit	2	902.00	5.25	9471.00	
Supported Employment Idaho Medicaid Plus	☐	Per 15 Minute Unit	5	902.00	5.25	23677.50	
Attendant Care Total:							12774072.45
Attendant Care MMCP	☐	Per 15 Minute Unit	818	1205.00	4.49	4425748.10	
Attendant Care	☐	Per 15 Minute Unit	532	1205.00	4.49	2878359.40	
Attendant Care Idaho Medicaid Plus	☐	Per 15 Minute Unit	1011	1205.00	4.49	5469964.95	
Adult Residential Care Total:							57736287.28
Adult Residential Care	☐	Per Diem	1417	248.00	37.03	13012934.48	
Adult Residential Care MMCP	☐	Per Diem	2178	248.00	37.03	20001532.32	
Adult Residential Care Idaho Medicaid Plus	☐	Per Diem	2692	248.00	37.03	24721820.48	
Chore Service Total:							259046.00
Chore Services	☐	Per 15 Minute Unit	96	152.00	4.01	58513.92	
Chore Service MMCP	☐	Per 15 Minute Unit	147	152.00	4.01	89599.44	
Chore Service Idaho Medicaid Plus	☐	Per 15 Minute Unit	182	152.00	4.01	110932.64	
Companion Services Total:							4595160.96
Companion Services MMCP	☐	Per 15 Minute Unit	227	1689.00	4.16	1594956.48	
Companion Services	☐	Per 15 Minute Unit	147	1689.00	4.16	1032857.28	
Companion Services Idaho Medicaid Plus	☐	Per 15 Minute Unit	280	1689.00	4.16	1967347.20	

GRAND TOTAL:	110713148.08
Total: Services included in capitation:	
Total: Services not included in capitation:	110713148.08
Total Estimated Unduplicated Participants:	13436
Factor D (Divide total by number of participants):	8240.04
Services included in capitation:	
Services not included in capitation:	8240.04
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultation Total:							**6205.68**
Consultation MMCP	☐	Per 15 Minute Unit	54	5.20	7.65	**2148.12**	
Consultation	☐	Per 15 Minute Unit	35	5.20	7.65	**1392.30**	
Consultation Idaho Medicaid Plus	☐	Per 15 Minute Unit	67	5.20	7.65	**2665.26**	
Environmental Accessibility Adaptations Total:							**110462.92**
Environmental Accessibility Adaptations	☐	Per Job	7	1.00	3563.32	**24943.24**	
Environmental Accessibility Adaptations MMCP	☐	Per Job	11	1.00	3563.32	**39196.52**	
Environmental Accessibility Adaptations Idaho Medicaid Plus	☐	Per Job	13	1.00	3563.32	**46323.16**	
Home Delivered Meals Total:							**2946121.76**
Home Delivered Meals	☐	Per Meal	583	218.00	5.23	**664701.62**	
Home Delivered Meals MMCP	☐	Per Meal	895	218.00	5.23	**1020425.30**	
Home Delivered Meals Idaho Medicaid Plus	☐	Per Meal	1106	218.00	5.23	**1260994.84**	
Non-medical Transportation Total:							**291293.20**
Non-medical Transportation MMCP	☐	Per Mile	414	554.00	0.44	**100916.64**	
Non-medical Transportation	☐	Per Mile	269	554.00	0.44	**65571.44**	
Non-medical Transportation Idaho Medicaid Plus	☐	Per Mile	512	554.00	0.44	**124805.12**	
Personal Emergency Response System Total:							**640983.92**
Personal	☐					**5006.32**	

GRAND TOTAL:	**110713148.08**
Total: Services included in capitation:	
Total: Services not included in capitation:	110713148.08
Total Estimated Unduplicated Participants:	**13436**
Factor D (Divide total by number of participants):	**8240.04**
Services included in capitation:	
Services not included in capitation:	8240.04
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Response System 1st Month Rent		Per Month (+	88	1.00	56.89		
Personal Emergency Response System Monthly Rent	☐	Per Month	458	9.00	33.83	139447.26	
Personal Emergency Response System MMCP	☐	Per Month	704	9.00	33.83	214346.88	
Personal Emergency Response System Idaho Medicaid Plus	☐	Per Month	870	9.00	33.83	264888.90	
PERS 1st Month Rent MMCP	☐	Per Month (+	136	1.00	56.89	7737.04	
PERS 1st Month Rent IMPlus	☐	Per Month (+	168	1.00	56.89	9557.52	
Skilled Nursing Total:							1393045.49
RN Nursing Services	☐	Per 15 Minute Unit	42	33.00	10.19	14123.34	
LPN Nursing Services	☐	Per 15 Minute Unit	35	619.00	7.31	158371.15	
Skilled Nursing MMCP	☐	Per Member Per Month	0	0.00	0.01	0.00	
Nursing Supervisory Visits	☐	Per Visit	1383	2.00	50.95	140927.70	
Skilled Nursing Idaho Medicaid Plus	☐	Per Member Per Month	0	0.00	0.01	0.00	
RN Nursing Services MMCP	☐	Per 15 Minute Unit	64	33.00	10.19	21521.28	
RN Nursing Services IMPlus	☐	Per 15 Minute Unit	79	33.00	10.19	26565.33	
Nursing Supervisory Visits MMCP	☐	Per Visit	2125	2.00	50.95	216537.50	
Nursing Supervisory Visits IMPlus	☐	Per Visit	2625	2.00	50.95	267487.50	
LPN Nursing Services MMCP	☐	Per 15 Minute Unit	54	619.00	7.31	244344.06	

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Services included in capitation:	
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Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
LPN Nursing Services IMPlus	☐	Per 15 Minute Unit	67	619.00	7.31	303167.63	
Specialized Medical Equipment and Supplies Total:							92848.56
Specialized Medical Equipment and Supplies MMCP	☐	Per Piece of Equipment	29	2.00	552.67	32054.86	
Specialized Medical Equipment and Supplies	☐	Per Piece of Equipment	19	2.00	552.67	21001.46	
Specialized Medical Equipment and Supplies Idaho Medicaid Plus	☐	Per Piece of Equipment	36	2.00	552.67	39792.24	
Transition Services Total:							46704.00
Transition Services	☐	Per Transition	13	1.00	834.00	10842.00	
Transition Services MMCP	☐	Per Transition	19	1.00	834.00	15846.00	
Transition Services Idaho Medicaid Plus	☐	Per Transition	24	1.00	834.00	20016.00	

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Total Estimated Unduplicated Participants:	13436
Factor D (Divide total by number of participants):	8240.04
Services included in capitation:	
Services not included in capitation:	8240.04
Average Length of Stay on the Waiver:	285