

NOTICE OF INTENT TO SEEK A 1915(b) WAIVER SOLICITATION OF PUBLIC INPUT

Pursuant to 42 C.F.R. § 441.304, the Idaho Department of Health and Welfare, Division of Medicaid (Department) provides public notice of its intent to seek a §1915(b) managed care waiver titled “Idaho Medicaid Plus” from the Centers for Medicare and Medicaid Services (CMS). In addition, the Aged and Disabled (A&D) §1915(c) waiver and Idaho Quality Strategy must be amended to align with the Idaho Medicaid Plus §1915(b) waiver application.

The Department assures these changes are in compliance with 42 CFR 440.345, and that individuals under twenty-one (21) years of age, pursuant to EPSDT, may receive additional services if determined medically necessary and prior authorized by the Department. Medicaid has consulted with Idaho Tribal representatives regarding this change in compliance with section 5006(e) of the American Recovery and Reinvestment Act of 2009.

Pursuant to 42 C.F.R. § 441.304, public notice of the proposed waiver and amendment will be published on **March 30, 2018** in the newspapers of widest circulation in each Idaho city with a population of 50,000 or more and on the Department’s website. On **April 2, 2018**, copies of the public notice and the proposed waiver application, waiver amendment, and Idaho Quality Strategy amendment will be made available for public review on the Department’s website and during regular business hours at any regional or field office of the Idaho Department of Health and Welfare and any regional or local public health district office. In Adams, Boise and Camas counties, copies will be available at each county clerk's office. The public will be given the opportunity to comment on the proposed Idaho Medicaid Plus waiver application, the Aged and Disabled Waiver amendment, and the Idaho Quality Strategy for a period of at least 30 days.

MANAGED CARE

The Idaho Medicaid Plus §1915(b) waiver will allow for a phased in mandatory Medicaid Managed Care Program for full dual-eligible individuals in counties where there are at least two participating health plans. A dual eligible individual is a person who has Medicare Parts A and B in addition to Enhanced Medicaid coverage. Currently, there are two participating health plans in Ada, Bannock, Bingham, Bonner, Bonneville, Canyon, Kootenai, Nez Perce, and Twin Falls counties.

The A&D §1915(c) waiver will be amended to align with the Idaho Medicaid Plus §1915(b) waiver application. The Idaho Quality Strategy will be revised to describe how the state will maintain oversight of the quality of the Idaho Medicaid Plus program.

PUBLIC REVIEW

A copy of the proposed Idaho Medicaid Plus application, the draft Aged and Disabled waiver amendment, and the revised Idaho Quality Strategy will be posted on the Department’s website at: <http://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx> no later than **April 2, 2018**.

Unless otherwise specified, copies of the proposed waiver application, amendment, and Idaho Quality Strategy are also available for public review during regular business hours at any regional Medicaid services office of the Idaho Department of Health and Welfare in addition to the locations listed below.

LOCATIONS FOR PUBLIC REVIEW OF PROPOSED CHANGES

Ada County

DHW Region 4, 1720 Westgate Drive, Boise, ID 83704

Central District Health Department, 707 North Armstrong Place, Boise, ID 83704

Adams County

Adams County Clerk's Office, 201 Industrial Avenue, Council, ID 83612

Bannock County

DHW Region 6, 1070 Hilina, Pocatello, ID 83201

Southeastern Idaho Public Health, 1901 Alvin Ricken Drive, Pocatello, ID 83201

Bear Lake County

Southeastern Idaho Public Health, 455 Washington, Suite #2, Montpelier, ID 83254

Benewah County

Panhandle Health District, 137 N 8th Street, St Maries, ID 83861

Bingham County

DHW Region 6, 701 East Alice, Blackfoot, ID 83221

Southeastern Idaho Public Health, 145 W Idaho Street, Blackfoot, ID 83221

Blaine County

South Central Public Health, 117 East Ash Street, Bellevue, ID 83313

Boise County

Boise County Clerk's Office, 420 Main Street, Idaho City, ID 83631

Bonner County

DHW Region 1, 207 Larkspur Street, Ponderay, ID 83852

Panhandle Health District, 2101 W. Pine Street, Sandpoint, ID 83864

Bonneville County

DHW Region 7, 150 Shoup Avenue, Idaho Falls, ID 83402

Eastern Idaho Public Health, 1250 Hollipark Drive, Idaho Falls, ID 83401

Boundary County

Panhandle Health District, 7402 Caribou Street, Bonners Ferry, ID 83805

Butte County

Southeastern Idaho Public Health, 178 Sunset Drive, Arco, ID 83213

Camas County

Camas County Clerk's Office, 501 Soldier Road, Fairfield, ID 83327

Canyon County

DHW Region 3, 3402 Franklin Road, Caldwell, ID 83605

Southwest District Health, 13307 Miami Lane, Caldwell, ID 83607

Caribou County

Southeastern Idaho Public Health, 55 East 1st South, Soda Springs, ID 83276

Cassia County

DHW Region 5, 2241 Overland Avenue, Burley, ID 83318

Clark County

Eastern Idaho Public Health, 332 West Main, Dubois, ID 83423

Clearwater County

North Central Health District, 105 115th Street, Orofino, ID 83544

Custer County

Eastern Idaho Public Health, 1050 N. Clinic Road, Suite A, Challis, ID 83226

Elmore County

DHW Region 4, 2420 American Legion Blvd., Mountain Home, ID 83647

Central District Health Department, 520 E. 8th Street N, Mountain Home, ID 83647

Franklin County

DHW Region 6, 223 North State, Preston, ID 83263

Southeastern Idaho Public Health, 50 West 1 St. South, Preston, ID 83263

Fremont County

Eastern Idaho Public Health, 45 South 2nd West, St. Anthony, ID 83445

Gem County

Southwest District Health, 1008 East Locust, Emmett, ID 83617

Gooding County

South Central Public Health, 255 North Canyon Drive, Gooding, ID 83330

Idaho County

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DHW Region 2, Camas Resource Center, 216 South C Street, Grangeville, ID 83530

North Central Health District, 903 W Main, Grangeville, ID 83530

Jefferson County

Eastern Idaho Public Health, 380 Community Lane, Rigby, ID 83442

Jerome County

South Central Public Health, 951 East Avenue H, Jerome, ID 83338

Kootenai County

DHW Region 1, 1120 Ironwood Drive, Coeur d'Alene, ID 83814

Panhandle Health District, 8500 N. Atlas Road, Hayden, ID 83835

Latah County

DHW Region 2, 1350 Troy Highway, Moscow, ID 83843

North Central Health District, 333 E Palouse River Drive, Moscow, ID 83843

Lemhi County

DHW Region 7, 111 Lillian Street, Suite 104, Salmon, ID 83467

Eastern Idaho Public Health, 801 Monroe, Salmon, ID 83467

Lewis County

North Central Health District, 132 N Hill Street, Kamiah, ID 83536

Lincoln County

South Central Public Health, Lincoln County Community Center, 201 South Beverly St., Shoshone, ID 83352

Madison County

DHW Region 7, 333 Walker Drive, Rexburg, ID 83440

Eastern Idaho Public Health, 314 North 3rd East, Rexburg, ID 83440

Minidoka County

South Central Public Health, 485 22nd Street, Heyburn, ID 83336

Nez Perce County

DHW Region 2, 1118 F Street, Lewiston, ID 83501

North Central Health District, 215 10th Street, Lewiston, ID 83501

Oneida County

Southeastern Idaho Public Health, 175 South 300 East, Malad, ID 83252

Owyhee County

Southwest District Health, 132 E. Idaho, Homedale, ID 83628

Payette County

DHW Region 3, 515 N. 16th Street, Payette, ID 83661

Southwest District Health, 1155 Third Avenue North, Payette, ID 83661

Power County

Southeastern Idaho Public Health, 590 1/2 Gifford, American Falls, ID 83211

Shoshone County

DHW Region 1, 35 Wildcat Way, Suite B, Kellogg, ID 83837

Panhandle Health District, 114 Riverside Avenue W, Kellogg, ID 83837

Teton County

Eastern Idaho Public Health, 820 Valley Centre Drive, Driggs, ID 83422

Twin Falls County

DHW Region 5, 601 Pole Line Road, Twin Falls, ID 83301

South Central Public Health, 1020 Washington Street North, Twin Falls, ID 83301

Valley County

Central District Health Department, 703 1st Street, McCall, ID 83638

Washington County

Southwest District Health, 46 West Court, Weiser, ID 83672

PUBLIC COMMENT

The Department is accepting written and recorded comments regarding these waiver renewal applications for a period of 30 calendar days. **Comments must be submitted by one of the methods below by close of business on Monday, May 1, 2018.**

Hand Deliver to: Medicaid Central Office

Idaho Department of Health and Welfare

3232 W. Elder Street

Attn: Ali Fernández

Boise, ID 83705

Mail to: PO Box 83720

Boise, ID 83720-0036

FAX: (208) 332-7283

Email: IdahoMMCP@dhw.idaho.gov

The Department will review all comments received prior to submitting the waiver application, amendment, and Idaho Quality Strategy to CMS. A summary document of the comments received in addition to the Department's response will be posted online once they have been reviewed and compiled.

IDAHO MEDICAID PLUS

Draft 1915(b) Waiver Application

Facesheet: 1. Request Information (1 of 2)

A. The **State of Idaho** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

B. **Name of Waiver Program(s):** Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program
ID Medicaid Plus	Idaho Medicaid Plus	MCO;

Waiver Application Title (optional - this title will be used to locate this waiver in the finder):

Idaho Medicaid Plus

C. **Type of Request.** This is an:

Initial request for a new waiver.

Migration Waiver - this is an existing approved waiver

Provide the information about the original waiver being migrated

Base Waiver Number:

Requested Approval Period: (For

Amendment Number (if applicable):

waivers requesting three, four, or five year approval periods, the waiver must serve

Effective Date: (mm/dd/yy)

individuals who are dually eligible for Medicaid and Medicare.)

1 year 2 years 3 years 4 years 5 years

Draft ID: ID.015.00.00

D. **Effective Dates:** This waiver is requested for a period of 5 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

Proposed Effective Date: (mm/dd/yy)

10/01/18

Proposed End Date: 09/30/23

Calculated as "Proposed Effective Date" (above) plus "Requested Approval Period" (above) minus one day.

Facesheet: 2. State Contact(s) (2 of 2)

E. **State Contact:** The state contact person for this waiver is below:

Name:

Alexandra Fernandez

Phone:

(208) 287-1179

Ext:

If the State

TTY contact

information is

Fax:

(208) 332-7283

E-mail:

Alexandra.Fernandez@dh

different for any
of the

authorized programs, please check the program name below and provide the contact information.

The State contact information is different for the following programs:

Idaho Medicaid Plus

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

Section A: Program Description

Part I: Program Overview

Tribal consultation.

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

The Idaho Department of Health and Welfare (hereafter referred to as the "Department") sent tribal notifications on March 23, 2018 to the federally recognized tribes in Idaho (Coeur d'Alene, Kootenai, Nez Perce, Northwestern Band of the Shoshone Nation, Shoshone-Bannock and Shoshone-Paiute tribes) regarding the proposed Idaho Medicaid Plus program for duals that are not enrolled in the Idaho Medicare Medicaid Coordinated Plan (MMCP). These notices explained the purpose of Idaho Medicaid Plus. These proposed changes and updates will be discussed at the Tribal Quarterly meeting on May 23, 2018. Notices sent to tribal representatives solicit feedback from the tribes on the proposed changes. Tribal members are exempt from mandatory enrollment into Idaho Medicaid Plus under this waiver.

Program History required for renewal waivers only.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

- 1. Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

- a. **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
 -- *Specify Program Instance(s) applicable to this authority*
 ID Medicaid Plus
- b. **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
 -- *Specify Program Instance(s) applicable to this authority*
 ID Medicaid Plus
- c. **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
 -- *Specify Program Instance(s) applicable to this authority*
 ID Medicaid Plus
- d. **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
 -- *Specify Program Instance(s) applicable to this authority*
 ID Medicaid Plus

The 1915(b)(4) waiver applies to the following programs

- MCO**
 PIHP
 PAHP

- PCCM** (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
- FFS Selective Contracting program**

Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

2. Sections Waived. Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

- a. **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
-- *Specify Program Instance(s) applicable to this statute*
- ID Medicaid Plus**
- b. **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
-- *Specify Program Instance(s) applicable to this statute*
- ID Medicaid Plus**
- c. **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
-- *Specify Program Instance(s) applicable to this statute*
- ID Medicaid Plus**
- d. **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

-- *Specify Program Instance(s) applicable to this statute*

ID Medicaid Plus

- e. **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

-- *Specify Program Instance(s) applicable to this statute*

ID Medicaid Plus

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
Idaho Code §56-263 provides direction to Idaho Medicaid to develop a plan for managed care for dual eligibles.

Idaho Medicaid will concurrently promulgate changes to Idaho Administrative Rules (IDAPA) to align with the program described in this waiver. Temporary rules will go before the 2019 Idaho legislature for final approval; contingent upon securing approval from CMS to operate this 1915(b) waiver.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

1. Delivery Systems. The State will be using the following systems to deliver services:

- a. **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.
- b. **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.
- The PIHP is paid on a risk basis**
- The PIHP is paid on a non-risk basis**
- c. **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.
- The PAHP is paid on a risk basis**
- The PAHP is paid on a non-risk basis**
- d. **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.
- e. **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.
- the same as stipulated in the state plan**
- different than stipulated in the state plan**
- Please describe:

- f. **Other:** (Please provide a brief narrative description of the model.)

Idaho Medicaid has a Medicare-Medicaid Coordinated Plan (MMCP) for dual-eligible individuals who enroll with a participating Medicare Advantage plan. This model is a voluntary program that

permits a dual-eligible beneficiary to enroll in a single managed care organization (MCO) that receives capitation payments to deliver both Medicaid and Medicare services to the individual.

As a result of Idaho legislative direction in House Bill 260 in 2011, the Department is developing a managed long-term services and supports (MLTSS) program, Idaho Medicaid Plus, for dual-eligible individuals who have not elected to enroll in the MMCP. Idaho Medicaid Plus will integrate behavioral health and long term services and supports and provide more efficient coordination of care than the FFS delivery system.

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

2. **Procurement.** The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

Procurement for MCO

- Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- Open** cooperative procurement process (in which any qualifying contractor may participate)
- Sole source** procurement
- Other** (please describe)

Procurement for PIHP

- Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- Open** cooperative procurement process (in which any qualifying contractor may participate)
- Sole source** procurement
- Other** (please describe)

Procurement for PAHP

- Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- Open** cooperative procurement process (in which any qualifying contractor may participate)
- Sole source** procurement
- Other** (please describe)

Procurement for PCCM

- Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- Open** cooperative procurement process (in which any qualifying contractor may participate)
- Sole source** procurement
- Other** (please describe)

Procurement for FFS

- Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- Open** cooperative procurement process (in which any qualifying contractor may participate)
- Sole source** procurement
- Other** (please describe)

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Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

The Department has developed a new contract with the existing Health Plans that currently operate the MMCP to administer the Idaho Medicaid Plus program. Medicaid seeks to phase-in implementation of mandatory enrollment by county. Expansion of mandatory enrollment beyond the initial county will be contingent upon the Health Plans meeting performance benchmarks and approval of subsequent waiver amendments and associated contracts.

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (1 of 3)

1. Assurances.

- The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.
- The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

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2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

Program: " Idaho Medicaid Plus. "

- Two or more MCOs**
- Two or more primary care providers within one PCCM system.**
- A PCCM or one or more MCOs**
- Two or more PIHPs.**
- Two or more PAHPs.**
- Other:**

please describe

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Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

3. Rural Exception.

- The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52 (b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. 1915(b)(4) Selective Contracting.

- Beneficiaries will be limited to a single provider in their service area**
Please define service area.

- Beneficiaries will be given a choice of providers in their service area**

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

1. General. Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

- **Statewide** -- all counties, zip codes, or regions of the State
-- *Specify Program Instance(s) for Statewide*
 - ID Medicaid Plus**
- **Less than Statewide**
-- *Specify Program Instance(s) for Less than Statewide*
 - ID Medicaid Plus**

2. Details. Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Twin Falls/Bannock/Bingham/Bonneville/Ada/Canyon/Bonner/Kootenai/Nez Perce	MCO	Blue Cross of Idaho
Twin Falls/Bannock/Bingham/Bonneville/Ada/Canyon/Bonner/Kootenai/Nez Perce	MCO	Molina HealthCare of Idaho

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Twin Falls county has been selected as the pilot county for Idaho Medicaid Plus, with the intention of expanding over time to all counties in which there are two or more participating Health Plans that administer Idaho Medicaid Plus. Expansion into additional counties will be contingent upon successful implementation in Twin Falls county and upon the participating Health Plans meeting the performance expectations established in the contract for Idaho Medicaid Plus.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. Included Populations. The following populations are included in the Waiver Program:

- Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
 - Mandatory enrollment**
 - Voluntary enrollment**
- Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
 - Mandatory enrollment**
 - Voluntary enrollment**
- Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.
 - Mandatory enrollment**
 - Voluntary enrollment**
- Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
 - Mandatory enrollment**
 - Voluntary enrollment**
- Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.
 - Mandatory enrollment**
 - Voluntary enrollment**
- Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.
 - Mandatory enrollment**
 - Voluntary enrollment**

- TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children’s Health Insurance Program (SCHIP) through the Medicaid program.
- Mandatory enrollment**
- Voluntary enrollment**

- Other** (Please define):

Idaho Medicaid Plus will be available to individuals residing in the approved geographic service area who meet all of the following criteria:

- Age 21 and older at the time of enrollment
- Entitled to benefits under Medicare Part A, enrolled under Medicare Parts B and D, and receive full Medicaid state plan benefits.
- Aged and Disabled waiver (ID.1076) members who meet all other Idaho Medicaid Plus criteria are also required to enroll.

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

- 2. Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the “Aged” population may be required to enroll into the program, but “Dual Eligibles” within that population may not be allowed to participate. In addition, “Section 1931 Children” may be able to enroll voluntarily in a managed care program, but “Foster Care Children” within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

- Medicare Dual Eligible** --Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))
- Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.
- Other Insurance** --Medicaid beneficiaries who have other health insurance.
- Reside in Nursing Facility or ICF/IID** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).
- Enrolled in Another Managed Care Program** --Medicaid beneficiaries who are enrolled in another Medicaid managed care program
- Eligibility Less Than 3 Months** --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.
- Participate in HCBS Waiver** --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).
- American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.
- Special Needs Children (State Defined)** --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.
All individuals under age 21 are excluded.

- SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.
- Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.
- Other** (Please define):
 - The following populations will be excluded from enrollment in the MMCP:
 - Individuals under the age of 21
 - Individuals served under the Idaho Adult Developmental Disabilities 1915(c) Waiver (ID.0076)

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. Assurances.

- The State assures CMS that services under the Waiver Program will comply with the following federal requirements:
 - Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
 - Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
 - Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51 (b)
 - The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).
- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.
- The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

- 2. Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

- The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

Emergency Services Category General Comments (optional):

- 3. Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

- The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.
- The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.
- The State will pay for all family planning services, whether provided by network or out-of-network providers.
- Other (please explain):

- Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

4. FQHC Services. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

- The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.
- The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

- The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

FQHC Services Category General Comments (optional):

All members enrolled in Idaho Medicaid Plus have Medicare as a primary payer. Consequently, their access to FQHC services is not impacted by the Idaho Medicaid Plus MCO.

5. EPSDT Requirements.

- The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

EPSDT Requirements Category General Comments (optional):

Not applicable. All members served under Idaho Medicaid Plus are over age 21.

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

- This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

1915(b)(3) Services Requirements Category General Comments:

7. Self-referrals.

- The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Self-referrals Requirements Category General Comments:

Self-referrals are allowed for the following services:

- 1) Emergency services
- 2) Urgent care services
- 3) Family planning services

8. Other.

Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

The goal of this initiative is to improve coordination of care for all full-benefit Medicare-Medicaid enrollees (“dual eligibles”) to improve beneficiary health and quality of life and enhance the quality and cost-effectiveness of long-term services and supports for this vulnerable population.

Dual eligibles often have difficulty navigating the complex Medicare and Medicaid systems to properly address their extensive medical needs, frequent care transitions, and interactions with multiple providers and provider types in various settings. Many complications arise because Medicare and Medicaid were not designed with an intention to serve people in both programs in a coordinated manner. As a result, there are different Medicare and Medicaid rules and processes for enrollment, benefits, appeals, administration, marketing, financing, and more. This current state of misalignment means that dual eligibles can greatly benefit from an approach under which one entity coordinates their full range of interactions with the health care system.

Consequently, Idaho has offered a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) under the MMCP since 2014 which provides integrated, comprehensive, seamless coverage to dual eligibles. The expanded delivery system has aligned the care delivery model and payment methodology to ensure high-quality, efficient care that leads to better health for Idaho’s dual eligible citizens. The established MMCP ensures that all necessary Medicaid and Medicare services (including primary and acute care, pharmacy, behavioral health, and long-term supports and services) not otherwise carved out are provided, coordinated, and managed by the Health Plan. 1915(c) Developmental Disability Waiver services, 1915(i) developmental disabilities services, dental benefits, and non-emergency medical transportation will be carved out of the program and will continue to be covered through the Medicaid fee-for-service system.

Due to the limitations on passive or mandatory enrollment into Medicare Advantage plans, Idaho Medicaid intends to pilot Idaho Medicaid Plus as an improved service delivery system for those dual eligibles who have not elected to enroll into the more integrated MMCP.

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

1. Assurances for MCO, PIHP, or PAHP programs

- The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.
- The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

- a.** **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1. PCPs

Please describe:

2. Specialists

Please describe:

3. Ancillary providers

Please describe:

4. Dental

^
v

Please describe:

5. Hospitals

^
v

Please describe:

6. Mental Health

^
v

Please describe:

7. Pharmacies

^
v

Please describe:

8. Substance Abuse Treatment Providers

^
v

Please describe:

9. Other providers

^
v

Please describe:

^
v

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

- b.** **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State’s PCCM Program includes established standards for appointment scheduling for waiver enrollee’s access to the following providers.

- 1.** PCPs

Please describe:

^
v

- 2. Specialists

Please describe:

- 3. Ancillary providers

Please describe:

- 4. Dental

Please describe:

- 5. Mental Health

Please describe:

- 6. Substance Abuse Treatment Providers

Please describe:

- 7. Urgent care

Please describe:

- 8. Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

- c. **In-Office Waiting Times:** The State’s PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

- 1. PCPs

Please describe:

2. Specialists

^
v

Please describe:

3. Ancillary providers

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v

Please describe:

4. Dental

^
v

Please describe:

5. Mental Health

^
v

Please describe:

6. Substance Abuse Treatment Providers

^
v

Please describe:

7. Other providers

^
v

Please describe:

^
v

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. Other Access Standards

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v

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

- 3. Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

- The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.
- The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

- 2. Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

- a.** The State has set **enrollment limits** for each PCCM primary care provider.

Please describe the enrollment limits and how each is determined:

- b.** The State ensures that there are adequate number of PCCM PCPs with **open panels**.

Please describe the State's standard:

^
v

- c. The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

Please describe the State's standard for adequate PCP capacity:

^
v

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. Details for PCCM program. (Continued)

- d. The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal
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Please note any limitations to the data in the chart above:

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v

- e. The State ensures adequate **geographic distribution** of PCCMs.

Please describe the State's standard:

^
v

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

- f. **PCP:Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios.

Area/(City/County/Region)	PCCM-to-Enrollee Ratio
---------------------------	------------------------

Please note any changes that will occur due to the use of physician extenders.:

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v

- g. **Other capacity standards.**

Please describe:

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v

Section A: Program Description

Part II: Access**B. Capacity Standards (5 of 6)**

- 3. Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

Section A: Program Description**Part II: Access****B. Capacity Standards (6 of 6)**

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description**Part II: Access****C. Coordination and Continuity of Care Standards (1 of 5)****1. Assurances for MCO, PIHP, or PAHP programs**

- The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description**Part II: Access****C. Coordination and Continuity of Care Standards (2 of 5)****2. Details on MCO/PIHP/PAHP enrollees with special health care needs.**

The following items are required.

- a. The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208.

Please provide justification for this determination:

- b.** **Identification.** The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State.

Please describe:

Enrollees that require institutional level of care will be identified to the health plan in accordance with 42 CFR 438.208. This information is available to the Health Plans via a standard 834 file transaction.

- c.** **Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe:

Please describe the enrollment limits and how each is determined:

Enrollees will receive a Wellness Assessment of medical, behavioral health, substance use, LTSS and social needs. Assessment domains may include: social, functional, medical, behavioral, wellness and prevention, and Enrollees' preferences, strengths and goals. Each Health Plan must submit their assessment template to the Department for review and approval. Relevant and comprehensive sources, including the Enrollee, providers, family/caregivers/service providers, etc., will be used. Results are used to confirm the risk stratification level and the basis for developing the Individualized Care Plan. All Enrollees receive an assessment within 90 days of enrollment and at least annually thereafter. A reassessment must be completed when there is a change in the Enrollee's health and/or functional status that results in an increased need for services and supports, a significant health care event, or as requested by the Enrollee. Assessments will be conducted by health professionals who possess an appropriate professional scope of practice, licensure, and/or credentials, and are appropriate for responding to or managing the Enrollee's needs. There are no enrollment limits.

- d.** **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:
1. Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee.
 2. Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
 3. In accord with any applicable State quality assurance and utilization review standards.

Please describe:

- e.** **Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

Please describe:

The Health Plans must have a process in place ensuring that enrollees are permitted to directly access specialists, under appropriate circumstances. This provision is included as part of the contract with the Health Plans.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

3. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

- a. Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
- b. Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
- c. Each enrollee is receives **health education/promotion** information.

Please explain:

- d. Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. There is appropriate and confidential **exchange of information** among providers.
- f. Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- g. Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
- h. **Additional case management** is provided.

Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files.

- i. **Referrals.**

Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

4. Details for 1915(b)(4) only programs: If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program. In accordance with 42 CFR 438.207, the Health Plans must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

The Health Plans must maintain a network of appropriate providers, supported by written agreements, sufficient to provide adequate access to all services covered under the contract, and the Health Plan must comply with federal requirements in 42 CFR §422.112 regarding access to services. The enrollee may choose from the available providers within a health plan's network.

1. Medical and pharmacy network adequacy requirements will be based on Medicare requirements.
2. The State's network adequacy requirements will be used for Medicaid-only services.

For services for which Medicaid is the traditional primary payer (including LTSS and Community-Based Outpatient Behavioral Health Services), each Enrollee must have a choice of at least two providers located within:

- i. 30 miles or within 30 minutes of travel within Ada, Bannock, Bonneville, Canyon, Kootenai, Nez Perce, and Twin Falls counties, and
- ii. Within 45 miles or within 45 minutes in all other counties.

For LTSS provider types that travel to the Enrollee to deliver services, the Health Plans shall ensure that the provider-to-Enrollee ratio is comparable to the provider-to-participant ratio in FFS Medicaid.

Additionally, the Health Plans must offer a transition period of the first ninety (90) days of enrollment during which the enrollee may continue to receive services from providers with whom there was already a relationship.

Each enrollee will have a care specialist and an Individualized Care Plan to ensure improved care coordination. The care specialist must communicate with other providers and health care facilities about any health issues that could affect an enrollee's care.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs

- The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.
- The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:

05/31/18

 (mm/dd/yy)

- The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004.

Please provide the information below (modify chart as necessary):

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	Telligen		All mandatory activities as described in §438.358	N/A
PIHP				

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

- The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.
- The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part III: Quality

3. Details for PCCM program. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

- a. The State has developed a set of overall quality **improvement guidelines** for its PCCM program.

Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

- b. **State Intervention:** If a problem is identified regarding the quality of services received, the State will intervene as indicated below.
1. Provide education and informal mailings to beneficiaries and PCCMs
 2. Initiate telephone and/or mail inquiries and follow-up
 3. Request PCCM's response to identified problems
 4. Refer to program staff for further investigation
 5. Send warning letters to PCCMs
 6. Refer to State's medical staff for investigation
 7. Institute corrective action plans and follow-up
 8. Change an enrollee's PCCM
 9. Institute a restriction on the types of enrollees
 10. Further limit the number of assignments
 11. Ban new assignments
 12. Transfer some or all assignments to different PCCMs
 13. Suspend or terminate PCCM agreement
 14. Suspend or terminate as Medicaid providers
 15. Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

- c. **Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
 - A. Initial credentialing
 - B. Performance measures, including those obtained through the following (check all that apply):
 - The utilization management system.
 - The complaint and appeals system.
 - Enrollee surveys.
 - Other.

Please describe:

4. Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
5. Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
6. Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
7. Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

- d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

- 4. Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:
1. Provider Selection Process:
 - The Department will contract with managed care entities that are D-SNP providers that are willing and qualified to execute the functions described in the contract.
 - The Health Plans must demonstrate they are ready to implement the program by successfully passing a Readiness Review prior to go-live of the program.

 2. How the State assures quality in the services:
 - The Department requires the Health Plans to report on all aspects of programming, network functioning, utilization management, service delivery, and operations and claims processing as well as all other areas of performance required by the contract.
 - The Department will monitor the contract on a monthly basis.
 - The Department will draw conclusions from the data provided by the Health Plans in combination with the data the State directly collects and will report level of compliance with performance requirements back to the Health Plans via routine Contract Monitor Reports.
 - In the event the deficiencies are detected, the Health Plans are required to submit to the Department their corrective action and ameliorative processes to ensure improved quality.
 - The Department will continue in an iterative process of obtaining data and working with the Health Plans to ensure continuous quality improvement.
 - In accordance with 42 CFR 438.350, an External Quality Review Organization (EQRO) will complete an annual quality review on each health plan.

 3. Quality and Performance Standards:
The Health Plans must:
 - Engage in ongoing quality assurance work that includes reporting on quality of care concerns and submitting plans for how the deficits in quality will be addressed.
 - Conduct enrollee and provider satisfaction surveys and must incorporate such feedback into its policies, procedures and operations.
 - Report performance quarterly and annually to the State using measures provided by the State.
 - Use industry recognized methodologies to analyze quality assurance data.
 - Monitor performance of its provider network and have a plan for improving the network's performance.
 - Conduct utilization management activities and respond to over and under-utilization.
 - Establish a compliance program and conduct surveillance activities for fraud and abuse issues and must report on these findings.
 - Develop a Disaster Recovery Plan that describes how they will ensure continuity of service administration in the event of a disaster.

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

- The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.
- The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

a. Scope of Marketing

1. The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2. The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

Please list types of indirect marketing permitted:

Mailings, radio, and television advertising are permitted. The Health Plan may also post written outreach and promotional materials at sites statewide upon approval from the Department.

3. The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries).

Please list types of direct marketing permitted:

Direct mail is permitted. However, in accordance with 42 CFR 438.104, the Health Plan must not, either directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

b. Description. Please describe the State’s procedures regarding direct and indirect marketing by answering the following questions, if applicable.

- 1. The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

Please explain any limitation or prohibition and how the State monitors this:

The State allows the dissemination of token gift items to potential enrollees including nominal gifts such as pens, key chains, magnets, etc. Any gift with a monetary value exceeding \$25.00 is prohibited. Reports of gifts or other incentives in violation of this policy will be investigated by the Department as needed.

- 2. The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

- 3. The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

Spanish and each Limited English Proficiency group that constitutes five percent (5%) or more of Enrollees or one thousand (1,000) or more Enrollees in the Health Plan’s statewide service area, whichever is less.

The State has chosen these languages because (check any that apply):

- a. The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

b.

- The languages comprise all languages in the service area spoken by approximately percent or more of the population.

c. Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:

The Department will limit direct marketing and outreach activities to potential Enrollees outside of open enrollment periods to minimize potential misinformation.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

1. Assurances

- The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.
- The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. Details

a. Non-English Languages

1. Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

Spanish. Health plans will include a Spanish phrase in materials to inform Spanish-speaking members how to obtain a copy of the material in Spanish.

If the State does not translate or require the translation of marketing materials, please explain:

The State defines prevalent non-English languages as: (check any that apply):

- a. The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines "significant.":

Any Limited English Proficiency group that constitutes five percent (5%) or more of Enrollees or one thousand (1,000) or more Enrollees in the Health Plan's statewide service area, whichever is less.

- b. The languages spoken by approximately percent or more of the potential enrollee/enrollee population.
- c. Other

Please explain:

2. Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

The contract issued by the Department requires the Health Plans to establish policies to ensure Enrollees have access to oral interpretive services, at no cost to Enrollees, that are available statewide.

3. The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

Please describe:

Health Plans must offer informational materials to enrollees upon enrollment and ongoing. The Health Plans must offer access to customer service staff who can explain and answer questions about the managed care program.

State staff are also educated on the managed care program to be able to provide customer service to Enrollees and potential Enrollees.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

- State
- Contractor

Please specify:

Information is distributed by both the State and the Health Plans. All Enrollee and potential Enrollee materials require prior approval by the Department.

- There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP.)

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. Details (Continued)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

- the State
- State contractor

Please specify:

Information will be provided by the Health Plan. Enrollee and potential enrollee materials require prior approval by CMS and the Department unless both agree that one or the other entity is authorized to review and approve such documents on behalf of CMS and the Department.

- The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

The Department will distribute notices and materials to potential Enrollees to advise them of the open enrollment period during which they can make an active selection of a Health Plan to administer their Idaho Medicaid Plus program. Once the open enrollment period has concluded, the Health Plans are responsible for distributing materials to members enrolled with the plan through active selection or auto-assignment by the Department.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. Assurances

- The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.
- The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. Outreach

- The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

The Department is engaging in extensive outreach efforts to inform stakeholders of the implementation of Idaho Medicaid Plus. Outreach activities include:

- Town-hall style meetings with dual-eligible participants statewide. All dual eligible Medicaid beneficiaries received invitations to meetings hosted throughout the month of May 2018. Thirty-one (31) meetings were hosted in various locations throughout the state and at varying times of day to maximize opportunities for duals to attend.
- The Department presented at the Idaho Healthcare Conference in Post Falls, Sandpoint, and Boise in May 2018. The annual Healthcare Conference is a well-attended provider conference and includes a broad audience of stakeholders.
- Changes to Idaho Code (IDAPA) to align with the Idaho Medicaid Plus program require outreach as part of the rule promulgation process. A Negotiated Rulemaking meeting was hosted on May 16, 2018, in Twin Falls, 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. Public hearings to solicit additional testimony about the implementation of Idaho Medicaid Plus are scheduled for August 14, 15, and 16 in Boise, Idaho Falls, and Lewiston, respectively.
- Medicaid hosts quarterly Dual-Eligible Stakeholder meetings via WebEx to provide regular updates on the MMCP and will include updates on the progress of implementing Idaho Medicaid Plus.
- The MedicAide newsletter, which is a monthly digital communication distributed to Medicaid providers, has included articles with updates and information about the MMCP and will include information about the implementation of Idaho Medicaid Plus.
- Medicaid hosts a webpage dedicated to information and materials for Dual-Eligible stakeholders at <http://mmcp.dhw.idaho.gov> that is regularly updated.
- Medicaid staff also routinely provide education and informational presentations upon request for a variety of stakeholder groups, including
 - o SHIBA
 - o Justice Alliance for Vulnerable Adults (JAVA)
 - o State Independent Living Council
 - o Medicaid Personal Assistance Oversight Committee (subcommittee of the MCAC)
 - o Family Caregiver Alliance
 - o Idaho Healthcare Association (Skilled Nursing Facilities, Residential Assisted Living Facilities, hospitals)
 - o Idaho Association of Home Care Providers (Personal Assistance Agencies)
- The Department published notice 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, notifying stakeholders of the opportunities for comment on the 1915(b) waiver application during the week of April 2, 2018.

Section A: Program Description**Part IV: Program Operations****C. Enrollment and Disenrollment (3 of 6)****2. Details (Continued)**

b. Administration of Enrollment Process

- State staff conducts the enrollment process.
- The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.
- The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name:

Please list the functions that the contractor will perform:

- choice counseling
- enrollment
- other

Please describe:

- State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

During the open enrollment period, potential Enrollees may contact the Department to identify their Health Plan of choice. Department staff will complete the enrollment. Potential Enrollees may also contact their Health Plan of choice, in which case the Health Plan may also complete the enrollment.

The Department will complete Enrollee requests for disenrollment for cause and the enrollment into another participating Health Plan. Requests for disenrollment for cause will be effective the first of the month following the month in which the request was made.

Section A: Program Description**Part IV: Program Operations****C. Enrollment and Disenrollment (4 of 6)****2. Details (Continued)**

- c. Enrollment** . The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

- This is a **new** program.

Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

Idaho Medicaid Plus will be implemented in Twin Falls county effective October 1, 2018 with an open enrollment period occurring from July 1, 2018 through September 30, 2018.

The Department will phase in additional counties in which there are two or more participating Health Plans upon successful implementation in Twin Falls county and upon meeting the quality and performance standards as outlined in the contract with the Health Plans. The expansion of Idaho Medicaid Plus into additional counties will be contingent upon securing approval from CMS of amended contracts with the Health Plans.

- This is an **existing program** that will be expanded during the renewal period.

Please describe: Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

- If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i.

- Potential enrollees will have **day(s)** / **month(s)** to choose a plan.

- ii. There is an auto-assignment process or algorithm.

In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs:

Auto-assignment will be stratified by population to ensure equitable assignment of case mix between the Health Plans. Populations include: individuals residing in institutional settings, individuals receiving Home and Community-Based Services (HCBS), and individuals who do not receive or reside in institutional settings.

Individuals who voluntarily elect to disenroll from the more integrated MMCP are auto-assigned to the same Health Plan to administer their Idaho Medicaid Plus benefits to ensure a smooth transition.

- The State automatically enrolls beneficiaries.
- on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).
 - on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).
 - on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

- The State provides **guaranteed eligibility** of months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.
- The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

- The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

- The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.
- i. Enrollee submits request to State.
 - ii. Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
 - iii. Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.
- The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.
- The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

Enrollees may request disenrollment from their current Health Plan for the following reasons:

- (i) The enrollee moves out of the Idaho Medicaid Plus service area.
- (ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks.
- (iii) The enrollee needs related services to be performed at the same time; not all related services are available within the provider network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.
- (iv) For enrollees that use MLTSS, the enrollee would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider, would experience a disruption in their residence or employment.
- (v) Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs.

Upon disenrollment from the current Health Plan, the Enrollee will be assigned to another participating Health Plan.

- The State does not have a **lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.
- The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.
- i. MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

Please describe the reasons for which enrollees can request reassignment

An Enrollee may be subject to an optional involuntary disenrollment if the Enrollee's continued enrollment seriously impairs the Health Plan's ability to furnish services to either the individual or other Enrollees, provided the Enrollee's behavior is determined to be unrelated to an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

Upon disenrollment from the current Health Plan, the Enrollee will be assigned to another participating Health Plan.

- ii. The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.
- iii. If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.
- iv. The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. Assurances

- The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.
- The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.
- The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

1. **Assurances for All Programs** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:
 - a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
 - b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
 - c. other requirements for fair hearings found in 42 CFR 431, Subpart E.
- The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

2. **Assurances For MCO or PIHP programs.** MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.
 - The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. **Details for MCO or PIHP programs**
 - a. **Direct Access to Fair Hearing**
 - The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.
 - The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.
 - b. **Timeframes**

- The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is days (between 20 and 90).
- The State's timeframe within which an enrollee must file a **grievance** is days.

c. Special Needs

- The State has special processes in place for persons with special needs.

Please describe:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

- 4. Optional grievance systems for PCCM and PAHP programs.** States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

- The State has a grievance procedure for its PCCM and/or PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

The grievance procedures are operated by:

- the State
 the State's contractor.

Please identify:

- the PCCM
 the PAHP

- Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

Please describe:

- Has a committee or staff who review and resolve requests for review.

Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function:

- Specifies a time frame from the date of action for the enrollee to file a request for review.

Please specify the time frame for each type of request for review:

- Has time frames for resolving requests for review.

Specify the time period set for each type of request for review:

- Establishes and maintains an expedited review process.

Please explain the reasons for the process and specify the time frame set by the State for this process:

- Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.
- Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.
- Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Participants are required to exhaust the Health Plan appeal system before filing for a State Fair Hearing. In accordance with 42 CFR §438.408(f)(2), participants may file a request for a State Fair Hearing up to 120 calendar days from the date of the Health Plan's notice of resolution upholding the adverse benefit determination.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

- The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:
1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
 2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.
- The prohibited relationships are:
1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
 2. A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
 3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.
- The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915 (b) waiver programs to exclude entities that:

- Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
- Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
- Employs or contracts directly or indirectly with an individual or entity that is precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

- The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.
- State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.
- The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content, Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a “big picture” of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
 - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
 - There must be at least one checkmark in each column under “Evaluation of Program Impact.”
 - There must be at least one check mark in one of the three columns under “Evaluation of Access.”
 - There must be at least one check mark in one of the three columns under “Evaluation of Quality.”

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
Accreditation for Non-duplication	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Accreditation for Participation	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Consumer Self-Report data	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Data Analysis (non-claims)	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Enrollee Hotlines	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Focused Studies	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
	<input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Geographic mapping	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Independent Assessment	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Measure any Disparities by Racial or Ethnic Groups	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Network Adequacy Assurance by Plan	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Ombudsman	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
On-Site Review	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Performance Improvement Projects	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Performance Measures	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
	<input type="checkbox"/> FFS	<input type="checkbox"/> FFS	<input type="checkbox"/> FFS	<input type="checkbox"/> FFS	<input type="checkbox"/> FFS	<input type="checkbox"/> FFS
Periodic Comparison of # of Providers	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Profile Utilization by Provider Caseload	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Provider Self-Report Data	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Test 24/7 PCP Availability	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Utilization Review	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Other	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a “big picture” of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- MCO, PIHP, and PAHP programs:
 - There must be at least one checkmark in each column.

- **PCCM and FFS selective contracting programs:**
 - There must be at least one checkmark in each column under “Evaluation of Program Impact.”
 - There must be at least one check mark in one of the three columns under “Evaluation of Access.”
 - There must be at least one check mark in one of the three columns under “Evaluation of Quality.”

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
Accreditation for Non-duplication	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Accreditation for Participation	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Consumer Self-Report data	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Data Analysis (non-claims)	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Enrollee Hotlines	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Focused Studies	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Geographic mapping	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Independent Assessment	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
	<input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Measure any Disparities by Racial or Ethnic Groups	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Network Adequacy Assurance by Plan	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Ombudsman	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
On-Site Review	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Performance Improvement Projects	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Performance Measures	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Periodic Comparison of # of Providers	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Profile Utilization by Provider Caseload	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Provider Self-Report Data			

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Test 24/7 PCP Availability	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Utilization Review	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Other	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a “big picture” of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
 - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
 - There must be at least one checkmark in each column under “Evaluation of Program Impact.”
 - There must be at least one check mark in one of the three columns under “Evaluation of Access.”
 - There must be at least one check mark in one of the three columns under “Evaluation of Quality.”

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
Accreditation for Participation	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Consumer Self-Report data	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Data Analysis (non-claims)	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Enrollee Hotlines	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Focused Studies	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Geographic mapping	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Independent Assessment	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Measure any Disparities by Racial or Ethnic Groups	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Network Adequacy Assurance by Plan	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
	<input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Ombudsman	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
On-Site Review	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Performance Improvement Projects	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Performance Measures	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Periodic Comparison of # of Providers	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input checked="" type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Profile Utilization by Provider Caseload	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Provider Self-Report Data	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Test 24/7 PCP Availability	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Utilization Review			

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS
Other	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS	<input type="checkbox"/> MCO <input type="checkbox"/> PIHP <input type="checkbox"/> PAHP <input type="checkbox"/> PCCM <input type="checkbox"/> FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
ID Medicaid Plus	MCO;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Idaho Medicaid Plus

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

- a. **Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

- NCQA
- JCAHO
- AAAHC
- Other

Please describe:

- b. **Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

Activity Details:

- NCQA
- JCAHO
- AAAHC
- Other

Please describe:

c.

Consumer Self-Report data**Activity Details:**

Enrollee feedback is collected via a standardized Quality Survey used as part of the administration of the 1915(c) Aged and Disabled Waiver, in addition to an Issue Log tracking database.

Quality Survey.

Personnel Responsible: Bureau of Long Term Care (BLTC) Nurse Reviewers, Department Contract Monitor, Health Plan staff

Description of Activity: BLTC Nurse Reviewers conduct level-of-care assessments for Enrollees that access services under the 1915(c) Aged and Disabled Waiver. As part of the assessment process, Enrollees are asked questions pertaining to the quality of and access to HCBS.

Frequency of Use: Quarterly

Information Obtained: Data regarding quality of and access to HCBS by Enrollees, as well as data on Health Plan remediation of issues detected.

Issue Log

Personnel Responsible: Department Staff, Department Contract Monitor

Description of Activity: Regional Department staff who receive complaints from Enrollees or reports of potential issues with the administration of Idaho Medicaid Plus and MMCP log the report in a SharePoint Issue Log. The Issue Log is configured with automated notifications to route items appropriately to the correct Department staff for investigation and follow-up. The Department Contract monitor is responsible for overseeing the investigation and remediation of items on the Issue Log, in addition to aggregating data to identify potential trends or compliance issues on behalf of the Health Plans.

Frequency of Use: Ongoing

Information Obtained: Summary data regarding complaints or potential issues with the administration of the program.

CAHPS

Please identify which one(s):

State-developed survey

Disenrollment survey

Consumer/beneficiary focus group

d. **Data Analysis (non-claims)****Activity Details:**

The Health Plans supply routine monthly, quarterly, and annual reports that are validated during quarterly on-site audits.

Personnel Responsible: Health Plan staff, Department Contract Monitor

Description of Activity: The Health Plans supply regular reports on a variety of functions.

Reports include:

- Service denials by service type, including denial reason.
- Grievance and appeal logs.
- Critical Incident resolution.
- Systems availability and performance (claims and case management systems)
- Provider network data – timeliness of services and geographical access
- Care coordination reports
- Quality Management/Quality Improvement (QM/QI reports)

Frequency of Use: Monthly, Quarterly

Information Obtained: Data pertaining to Health Plan performance of contract functions across multiple areas, in addition to trends in performance over time.

Denials of referral requests

Disenrollment requests by enrollee

- From plan
- From PCP within plan
- Grievances and appeals data
- Other

Please describe:

e. **Enrollee Hotlines**

Activity Details:

The Health Plans must offer customer service to participants via phone during normal business hours, at least 40 hours per week, by trained representatives knowledgeable about contracted services. If the Health Plans elect to operate a Nurse Advice Line separately from the customer service line, it must be staffed by a Registered Nurse (or a healthcare professional with more advanced qualifications) and available twenty four (24) hours per day, seven (7) days per week.

Personnel Responsible: Health Plan staff, Department Contract Monitor

Description of Activity: The health plan will provide written documentation of the availability of these phone lines, along with the phone numbers and hours of operation.

Frequency of Use: Quarterly

Information Obtained: Written verification of the customer service phone number and hours of operation. The health plan will submit quarterly reports including call data (total number of calls, caller wait times, types of requests made by caller, etc.). In addition, the Department may request call logs or audio files of specific calls to investigate complaints or issues.

f. **Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

Activity Details:

g. **Geographic mapping**

Activity Details:

h. **Independent Assessment** (Required for first two waiver periods)

Activity Details:

In accordance with CFR 42.438.350, a qualified External Quality Review Organization (EQRO) will perform an annual external quality review for each contracting Health Plan.

Personnel Responsible: Department Contract Monitor

Description of Activity: An EQRO will perform an external quality review for each contracting Health Plan and report results to the Department.

Frequency of Use: Annual

Information Obtained: Health plan performance via the required EQR protocols.

i. **Measure any Disparities by Racial or Ethnic Groups**

Activity Details:

j. **Network Adequacy Assurance by Plan** [Required for MCO/PIHP/PAHP]

Activity Details:

In accordance with 42 CFR 438.207, the Department requires the Health Plans to develop and maintain networks of providers that are sufficient in number, mix, and geographic distribution to meet the needs of participants in each service area.

Personnel Responsible: Department Contract Monitor

Description of Activity: The Department will monitor provider network development, including enrollment, selection, and maintenance of the network to specifically identify the capacity to deliver the required services.

Frequency of Use: Annual

Information Obtained: The reports supplied by the health plans must identify the enrollment of network providers in relation their location in the state and ability to meet participants' needs. A provider network file in addition to a geographic access report is supplied on a semi-annual basis for evaluation by the Department.

- k. Ombudsman

Activity Details:

- l. On-Site Review

Activity Details:

The Department conducts quarterly on-site audits with the Health Plans.

Personnel Responsible: Department Contract Monitor and Contract Manager, Health Plans

Description of Activity: Department staff conduct quarterly on-site audits with the Health Plans to validate data supplied by the Health Plan in prior reporting periods and to conduct targeted reviews of specific compliance areas. The Department notifies the Health Plan in advance of any targeted compliance areas that will be evaluated during the on-site audit and selects a sample (of Enrollees, Providers, service codes, etc.) prior to the on-site visit to validate. The Health Plan is issued a Contract Monitor Report summarizing the Department's findings.

Frequency of Use: Quarterly

Information Obtained: Validation of data supplied by the Health Plans during routine reporting, in addition to evaluation of targeted compliance areas to evaluate Health Plan performance of contract functions.

- m. Performance Improvement Projects [Required for MCO/PIHP]

Activity Details:

The Department will require the Health Plans to, in accordance with 42 CFR 438.240, utilize an ongoing performance improvement program for the services it furnishes to its Enrollees. The program must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. The performance improvement plan must take into account performance measures required by the Department.

Personnel Responsible: Department Contract Monitor

Description of Activity: The Health Plans will send the Department a copy of their performance improvement plan and their evaluation of its effectiveness.

Frequency of Use: Annually and upon request.

Information Obtained: Planned measurements and interventions to improve performance, and effectiveness of performance improvement plans.

- Clinical
 Non-clinical

- n. Performance Measures [Required for MCO/PIHP]

Activity Details:

The Department requires the Health Plans to meet all minimum performance thresholds established in the contract.

Process

Personnel Responsible: Health Plan staff, Department Contract Monitor

Description of Activity: The Department maintains oversight of a variety of Health Plan processes, including: timely service authorization decisions, timely and accurate appeal and grievance resolutions, care coordination outreach to new Enrollees, and wellness assessment completion, among other contractually required processes. The Department Contract Monitor maintains oversight of these activities via routine reports delivered by the Health Plan, in addition to requesting ad hoc reports or conducting targeted reviews during quarterly on-site visits when potential issues are detected. Performance thresholds are established in the contract with the Health Plans. Failure to meet performance thresholds results in a request for corrective action.

Frequency of Use: Monthly, Quarterly, and Annual

Information Obtained: Health Plan compliance with process requirements outlined in the contract.

Health status/outcomes

Personnel Responsible: Health Plan, Department Contract Monitor

Description of Activity: The Health Plan is required to complete a wellness assessment for all new Enrollees and at least annually thereafter. The required timelines for completing wellness assessments are dependent upon the individual Enrollee's risk stratification level. The risk stratification level is assigned based on the Enrollee's current needs. This is monitored via the Care Coordination Assessment report, which is due from the Health Plan on a monthly basis. Data is validated during the quarterly on-site audit.

Frequency of Use: Monthly, Quarterly

Information Obtained: Health Plan compliance with risk stratification and care coordination outreach requirements.

Access/availability of care

Personnel Responsible: Health Plan, Department Contract Monitor

Description of Activity: The Health Plan is required to ensure its provider network is robust enough to ensure compliance with the access standards outlined in the contract. This data is supplied to the Department via routine reporting and validated during quarterly on-site audits.

Frequency of Use: Quarterly and Ongoing

Information Obtained: Health Plan compliance with access standards established in the contract.

Use of services/utilization

Personnel Responsible: Health Plan, Department Contract Monitor

Description of Activity: The Health Plan is required to identify Enrollees who are authorized to receive HCBS under the Aged and Disabled 1915(c) waiver who have not utilized a waiver service in over 30 days to conduct outreach to the Enrollee. In addition, the Health Plan is required to have procedures in place to detect both over-utilization and under-utilization of services.

Frequency of Use: Quarterly

Information Obtained: Health Plan compliance with contract requirements pertaining to utilization management and 1915(c) waiver assurances.

Health plan stability/financial cost of care

Personnel Responsible: Health Plan, Department Contract Monitor, Department Actuarial Firm

Description of Activity: The Health Plan is required to submit financial data on an annual basis to the Department's actuarial firm for the purposes of calculating the Medical Loss Ratio for the contract year. The Health Plan is required to maintain a Medical Loss Ratio corridor as specified in the contract.

Frequency of Use: Annual

Information Obtained: Validation that Health Plan expenses incurred meet the minimum required Medical Loss Ratio of 85%, and a determination of whether the capitation rate for the upcoming contract year must be adjusted.

- Process
- Health status/ outcomes
- Access/ availability of care
- Use of services/ utilization
- Health plan stability/ financial/ cost of care
- Health plan/ provider characteristics
- Beneficiary characteristics

o. **Periodic Comparison of # of Providers**

Activity Details:

The Department requires the Health Plans to submit a provider network report which includes information on all providers of Medicaid services, including physical, behavioral health, and long-term care providers.

Personnel Responsible: Department contract monitor

Description of Activity: The Department will review reports submitted by the Health Plans to ensure they meet contractual requirements regarding the number of providers for Medicaid services. The Health Plans are expected to ensure that there is a sufficient number and mix of providers to meet the needs of the Enrollees in the geographic service area.

Frequency of Use: Quarterly

Information Obtained: The Department will obtain information regarding whether network adequacy requirements are being met and whether the number of providers is increasing or decreasing.

p. **Profile Utilization by Provider Caseload (looking for outliers)**

Activity Details:

The Department's Medicaid Program Integrity Unit (MPIU) will have access to encounter data submitted by the Health Plans for analysis.

Personnel Responsible: MPIU staff

Description of Activity: MPIU staff conduct targeted data reviews of provider utilization to detect patterns that may be indicative of potential program integrity concerns. Once encounter data submission has been established between the Health Plans and the state's MMIS, MPIU will have access to Health Plan claims paid in addition to FFS claims data for analysis.

Frequency of Use: Ongoing

Information Obtained: Program integrity compliance on behalf of Health Plan network providers, in addition to information about Health Plan monitoring of potential program integrity concerns.

q. **Provider Self-Report Data**

Activity Details:

The Department requires the Health Plans to report data from provider surveys.

Personnel Responsible: Health Plan staff, Department Contract Monitor

Description of Activity: Health Plans are required to conduct a provider survey at least annually that captures provider satisfaction with utilization management as well as provider compliance with access standards. In the event that a Health Plan identifies deficiencies in either area, a plan that details the correct action taken to remediate the issue must accompany the report furnished to the Department.

Frequency of Use: Annual

Information Obtained: The Department will obtain information about provider satisfaction

with Health Plan utilization management policies and procedures, and provider compliance with access standards.

- Survey of providers
 Focus groups

- r. Test 24/7 PCP Availability

Activity Details:

- s. Utilization Review (e.g. ER, non-authorized specialist requests)

Activity Details:

The Department requires the Health Plans to adopt and implement utilization management practices sufficient to meet the needs of participants. Health Plans are required to submit policies and procedures associated with utilization management practices to the Department for approval prior to implementation and at least annually thereafter. The Department will be able to validate aspects of utilization review via encounter claims submission and on-site reviews.

Personnel Responsible: Department Contract Monitor

Description of Activity: The Department will monitor utilization of services derived from analyses of encounter claims data.

Frequency of Use: Annual

Information Obtained: The Department will obtain administrative claims data from the encounter claims submitted by the health plan, including information on high-cost claimants, emergency department visits, and Aged and Disabled Waiver service utilization.

- t. Other

Activity Details:

The Department monitors Health Plan marketing and outreach to ensure compliance with applicable contract requirements and state and federal regulations.

Personnel Responsible: Department Contract Monitor

Description of Activity: All Health Plan marketing and outreach materials, including direct mailers, call center scripts, and public-facing materials pertaining to Idaho Medicaid Plus must be prior approved by the Department. The Department utilizes a SharePoint for Health Plans to submit materials for review. The Department validates that Health Plans are only using approved materials during quarterly on-site audits and upon request in the event that potential issues are reported to the Department.

Frequency of Activity: Quarterly and Ongoing

Information Obtained: Health Plan compliance with marketing and outreach contract, state, and federal requirements.

Section C: Monitoring Results

Initial Waiver Request

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is an Initial waiver request.

- The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.**

IDAHO MEDICAID PLUS

Draft 1915(c) Aged and Disabled Waiver
Amendment

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 waiver's 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:

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

10/01/18

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:

The purpose of this amendment to Idaho's Aged and Disabled (A&D) 1915(c) waiver is to align with the 1915(b) waiver application 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 will require dual-eligibles who have not enrolled in the MMCP to enroll with a participating MCE that administers Idaho Medicaid Plus. The 1915(b) waiver is being submitted to permit mandatory enrollment in counties in which there are two or more participating MCEs with a phased-in implementation approach. The program will be piloted in Twin Falls county beginning on October 1, 2018, to be expanded into additional counties upon successful implementation and meeting performance thresholds.

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 include:

- 1) Updating references to the MMCP to include the Idaho Medicaid Plus program.
- 2) Updating references to MMCP Care Coordinators to include Idaho Medicaid Plus Care Specialists.
- 3) Updating Appendix I to reflect that the A&D waiver will also be operated in conjunction with a 1915(b) waiver for Idaho Medicaid Plus (in addition to the existing 1915(a)/(c) authority for MMCP).
- 4) Updating the Derivation of Estimates for Waiver Years 2 through 5 to reflect projected enrollment in Idaho Medicaid Plus under the 1915 (b) waiver, based on the anticipated geographic service area.

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)
<input checked="" type="checkbox"/> Waiver Application	Main, I. 6., Attachments
<input checked="" type="checkbox"/> Appendix A – Waiver Administration and Operation	5., 6. Quality Improvement
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	2.b., 6.i., 7.a., 8
<input type="checkbox"/> Appendix C – Participant Services	
<input checked="" type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	1.c., 1.d., 1.e., 1.f., 1.g.
<input checked="" type="checkbox"/> Appendix E – Participant Direction of Services	1.a., 1.l., 1.m.
<input checked="" type="checkbox"/> Appendix F – Participant Rights	1.
<input checked="" type="checkbox"/> Appendix G – Participant Safeguards	1.e., 2.b.
<input checked="" type="checkbox"/> Appendix H	1.a.
<input checked="" type="checkbox"/> Appendix I – Financial Accountability	2.b.
<input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	2.d.

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:

Ensure that the Aged and Disabled waiver aligns with the 1915(b) waiver application for the Idaho Medicaid Plus program.

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

Draft ID: ID.002.06.03

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 in 42 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 new waiver application 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 Eligibility 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 a 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) or Idaho Medicaid Plus, the managed care entities (MCE) will administer the waiver in accordance with the same rules by which BLTC administers the waiver for participants not enrolled in the MMCP or Idaho Medicaid Plus. 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 or Idaho Medicaid Plus. Any references to duties of the MCE apply only to individuals who are enrolled in the state's MMCP or Idaho Medicaid Plus.

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. **Statewidness.** Indicate whether the State requests a waiver of the statewidness requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

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

Geographic Limitation. A waiver of statewidness 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 statewidness 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 is engaging in extensive outreach efforts to inform stakeholders of the implementation of Idaho Medicaid Plus and opportunities to provide public comment on associated deliverables (including the Aged and Disabled waiver amendment). Outreach activities include:

1. The Personal Assistance Oversight Committee (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 upcoming availability of the draft waiver amendment, draft 1915(b) waiver application, and public comment period was discussed during the 3/21/2018 PAO meeting.
2. Tribal solicitations were mailed to the Tribal Representatives on 03/23/2018. In addition, ongoing feedback is solicited from Tribal representatives during the quarterly Tribal Meetings; the next meeting is scheduled for 05/23/2018.
3. Town-hall style meetings with dual-eligible participants statewide are scheduled for the month of May 2018. All dual eligible Medicaid beneficiaries statewide will receive invitations the week of April 23. Thirty-one (31) meetings will be hosted in various locations throughout the state and at varying times of day to maximize opportunities for duals to attend.
4. The Department will present at the Idaho Healthcare Conference in Post Falls, Sandpoint, and Boise in May 2018. The annual Healthcare Conference is a well-attended provider conference and includes a broad audience of stakeholders, and is an opportunity for the Department to share information about the implementation of Idaho Medicaid Plus and gather feedback.
5. Changes to Idaho Code (IDAPA) to align with the Idaho Medicaid Plus program require outreach as part of the rule promulgation process. A Negotiated Rulemaking meeting will be hosted on May 16, 2018, in Twin Falls, 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. Public hearings to solicit additional testimony about the implementation of Idaho Medicaid Plus are scheduled for August 14, 15, and 16 in Boise, Idaho Falls, and Lewiston, respectively.
6. The Department published notice 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, notifying stakeholders of the opportunities for comment on the 1915(b) waiver application and Aged and Disabled 1915(c) waiver amendment between March 30, 2018 and April 2, 2018.

The Department made the draft A&D waiver amendment, 1915(b) waiver application, and revised Managed Care Quality Strategy available for public review on April 2, 2018, in all regional Department of Health and Welfare offices and Public Health District Offices. In counties in which the Department does not have a regional office, the materials were made available at the County Clerk's office. These materials are also posted on the main Medicaid webpage at <https://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx> under "Proposed Changes & Public Notice for Waiver Services."

Public comment will be accepted via mail, email, fax, and telephone message from April 2, 2018 through close of business on May 1, 2018.

Public Feedback:

A document summarizing comments received and the State's respective responses will be posted on the Department's website at <http://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx> under the "Proposed Changes & Public Notice for Waiver Services" header. All comments and Department responses will be submitted to CMS concurrently with the amendment for consideration.

- 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:

Fernandez

First Name:

Alexandra

Title:

Bureau Chief

Agency:

Address:

Address 2:

City:

State: **Idaho**

Zip:

Phone: **Ext:** TTY

Fax:

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Idaho**

Zip:

Phone: **Ext:** TTY

Fax:

E-mail:

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:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Idaho**

Zip:

Phone: **Ext:** TTY

Fax:

E-mail:

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 1915(b) waiver to operate a mandatory managed care program, will 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 maintain their existing provider, even if the provider is out of the MCE network, for up to 90 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.

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

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.

Idaho assures that the setting transition plan included with this waiver will be subject to any provisions or requirements in the State's approved Statewide Transition Plan. The State will implement any applicable required changes upon approval of the Statewide Transition Plan and will make conforming changes to this waiver, as needed, when it submits the next amendment or renewal. The most recent version of the Statewide Transition Plan can be found here:

<http://healthandwelfare.idaho.gov/Medical/Medicaid/HomeandCommunityBasedSettingsFinalRule/tabid/2710/Default.aspx>

Overview

The intention of the home and community-based services (HCBS) rule is to ensure individuals receiving long-term services and supports through these waiver programs have full access to the benefits of community living and the opportunity to receive services in the most integrated settings appropriate. In addition, the new regulations aim to enhance the quality of HCBS and provide protections to participants.

Idaho Medicaid initiated a variety of activities beginning in July of 2014 designed to engage stakeholders in the development of this Transition Plan. The engagement process began with a series of web-based seminars that were hosted in July through September 2014 and which summarized the new regulations and solicited initial feedback from a wide variety of stakeholders. HCBS providers, participants, and advocates were invited to attend these seminars. The state also launched an HCBS webpage, www.HCBS.dhw.idaho.gov hosting information about the new regulations, FAQs, and updates regarding the development of Idaho's draft Transition Plan. The webpage contains an "Ask the Program" feature whereby interested parties are encouraged to submit comments, questions, and concerns to the project team at any time. Additional opportunities were established to share information and for stakeholders to provide input regarding the new regulations and Idaho's plans for transitioning into full compliance. They are described in more detail throughout this document.

The Transition Plan includes:

- A description of the work completed to date to engage stakeholders in this process
- A gap analysis of existing support for the new HCBS regulations
- A plan for assessment and monitoring of all residential and non-residential service settings
- Initial plans for remediation of providers and relocation for impacted participants
- A timeline for remaining activities to bring Idaho into full compliance
- A summary of public comments
- An index of changes made in version three of the Transition Plan

The state received comments from CMS on the Statewide Transition Plan on August 10, 2015, in the form of a letter. The state has since developed responses to the comments and also incorporated changes into the Transition Plan to address concerns identified. The CMS letter, along with the state's responses, has been posted on the state's webpage, www.HCBS.dhw.idaho.gov. They can be found under the Resources tab on the right hand side of the home page.

Additional changes to the body of this Transition Plan (v3) were made prior to it being posted on September 11, 2015. These changes incorporate updated information; include new details; and, in some instances, add clarifying information. All changes are noted in the Index of Changes (Attachment 5).

Section 1: Results of Idaho Medicaid's Initial Analysis of Settings

Idaho completed a preliminary gap analysis of its non-residential HCBS settings in December 2014. The gap analysis included an in-depth review of state administrative rule and statute, Medicaid waiver and state plan language, licensing and certification requirements, Medicaid

provider agreements, service definitions, administrative and operational processes, provider qualifications and training, quality assurance and monitoring activities, reimbursement methodologies, and person-centered planning processes and documentation. Please refer to the links provided in the Transition Plan Introduction for access to rule and waiver language. This analysis identified areas where the new regulations are supported in Idaho as well as areas that will need to be strengthened in order to align Idaho's HCBS programs with the regulations. The results of the analysis of residential settings were shared with stakeholders via a WebEx meeting on September 16, 2014. The results of the analysis of non-residential settings were shared with stakeholders via a WebEx meeting on January 14, 2015. The WebEx presentations and audio recordings were then posted on the Idaho HCBS webpage. This preliminary analysis has informed the recommendation to develop several changes to rule, operational processes, quality assurance activities, and program documentation.

Below is a list of service settings offered under this waiver. Settings that are listed as "in-home" are presumed to meet HCBS compliance, as these are furnished in a participant's private residence. Settings indicated as "community" are also presumed to meet the HCBS qualities, as they are furnished in the community in which the participant resides. Quality reviews of services and participant service outcome reviews will ensure that providers do not impose restrictions on HCBS setting qualities in a participant's own home or in the community without a supportive strategy that has been agreed to through the person-centered planning process.

Service settings for the A&D Waiver include: Adult Day Health centers, Developmental Disability Agencies, Residential Assisted Living Facilities, Certified Family Homes, private homes, or the community. The tables detailing Idaho's waiver services and the service settings in which those services may occur are located at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=7>

1a. Gap Analysis of Residential Settings

The A&D waiver offers HCBS services in two types of provider owned or controlled residential settings: RALFs and CFHs. The results of Idaho's analysis of these residential settings are summarized below, including an overview of existing support for each regulation. The state has included, where applicable, the full IDAPA citations to identify where IDAPA supports the HCBS requirement, in addition to indicating if IDAPA is silent. The state did not identify any IDAPA provision that conflicts with the HCBS requirements. Additionally, the chart includes preliminary recommendations on how to transition these settings into full compliance with the new regulations. Please note that the analysis of existing support for each new regulation is only the first step in the assessment process. It has been used to identify where Idaho lacks documented support for the setting quality requirements. Idaho understands that more work is necessary to complete a full assessment of settings. "Section 2: State Assessment and Remediation Plan" identifies the work remaining to complete a thorough assessment. That process includes soliciting input from individuals who live in and use these settings, provider self- assessment, as well as on-site validation of compliance.

In summary, the state determined that there were gaps in support for some of the HCBS setting qualities in RALFs and/or CFHs. Identified gaps included: lack of standards, lack of IDAPA support, and lack of oversight/monitoring to ensure compliance. Planned remediation activities include: development of standards to address access "to the same degree as individuals not receiving Medicaid HCBS;" rule promulgation to incorporate support for HCBS setting qualities into IDAPA; and enhanced monitoring and quality assurance activities to ensure ongoing compliance. The table containing the provider owned or controlled residential settings gap analysis is located at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=11>

Due to the gaps identified above, Idaho is unable to say at this time how many residential settings fully align with the federal requirements, how many do not comply and will require modifications, and how many cannot meet the federal requirements and require removal from the program and/or relocation of participants. Proposed plans to complete a full assessment are outlined in Section Two. Medicaid must first enact regulatory changes to allow enforcement and then complete the assessment of individual settings. The assessment will occur in 2017.

Non- Provider Owned or Controlled Residential Settings

Idaho's residential habilitation services include services and supports designed to assist participants to reside successfully in their own homes, with their families, or in a CFH. Residential habilitation services provided to the participant in their own home are called "supported living" and are provided by residential habilitation agencies. Supported living services can either be provided hourly or on a 24-hour basis (high or intense supports).

As part of Idaho's outreach and collaboration efforts, Medicaid initiated meetings with supported living service providers in September 2014. The goal of these meetings was to ensure that supported living providers understood the new HCBS setting requirements, how the requirements will apply to the work that they do, and to address any questions or concerns this provider group may have. During these meetings, providers expressed concern regarding how the HCBS setting requirements would impact their ability to implement strategies to reduce health and safety risks to participants receiving high and intense supports in their own homes. Because of these risk reduction strategies, supported living providers are concerned that they will be unable to ensure that all participants receiving supported living services have opportunities for full access to the greater community and that they are afforded the ability to have independence in making life choices.

Since our initial conversations with residential habilitation agency providers the state has addressed provider concerns by obtaining clarification from CMS and publishing draft HCBS rules. Our goal is that through individualized supportive strategies created by the participant and their person-centered planning team, agencies will support participants in integration, independence, and choice while

maintaining the health, safety, dignity, and respect of the participant and the community.

Although the HCBS regulations allow states to presume the participant's private home meets the HCBS setting requirements, the state will enhance existing quality assurance and provider monitoring activities to ensure that participants retain decision-making authority in their home. Additionally, the state is continuing to analyze the participant population receiving intense and high supported living and how the HCBS requirements impact them.

1b. Initial Analysis of Settings Presumed to be Institutional

The Centers for Medicare and Medicaid Services has identified three characteristics of settings that are presumed to be institutional. Those characteristics are:

1. The setting is in a publicly or privately owned facility providing inpatient treatment.
2. The setting is on the grounds of, or immediately adjacent to, a public institution.
3. The setting has the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS.

Idaho has completed its assessment of all settings against the first two characteristics of an institution. There are no settings where an HCBS participant lives or receives services that are located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment. Further, there are no settings on the grounds of or immediately adjacent to a public institution. Idaho will assess all settings against the third characteristic of an institution as part of its larger assessment effort in 2017. At this point in time Idaho has no plans to request the heightened scrutiny process for any HCBS setting.

Analysis of Residential Settings Presumed to be Institutional

Idaho Medicaid supports two residential settings that needed to be analyzed against the criteria established by CMS as presumptively institutional. They are CFHs and RALFs. As of the publication of the Transition Plan (v3), there are no CFHs or RALFs that are in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. Below is a description of the assessment process that led to this conclusion.

Certified Family Homes

As of September 2014, Idaho had 2,212 CFHs. A CFH is a private home setting in which a home care provider assists the participant with activities of daily living, provides protection and security, and encourages the participant toward independence. The CFH must assist the individual with establishing relationships and connecting with their community. Idaho Code 39-3501 states that the purpose of a CFH is to provide a homelike alternative designed to allow individuals to remain in a normalized family-styled living environment, usually within their own community. It further states that it is the intent of the legislature that CFHs be available to meet the needs of those residing in these homes while providing a homelike environment focused on integrated community living rather than other more restrictive environments and by recognizing the capabilities of individuals to direct their own care. Individuals in a CFH reside and interact with family members or other community members (visitors, friends, neighbors) who visit the CFH or vice versa. It is therefore assessed that these homes do not meet any of the three characteristics of an institution.

Residential Assisted Living Facilities

As of August 2014, Idaho had a total of 352 RALFs, each of which is licensed by the Division of Licensing and Certification. Of those, 204 RALFs billed Medicaid for services from February 2014 through July 2014. Note that these numbers are prone to change as facilities open and close or change the payer sources they will accept.

As of the publication of this Transition Plan, Idaho's assessment of RALFs against the characteristics of settings presumed to be institutional is complete. There are no RALFs that are in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. Below is a description of the assessment process leading to this conclusion.

The first step was to offer a WebEx meeting to stakeholders that provided an overview of the characteristics of settings presumed to be an institution. Stakeholders who were invited to that WebEx included providers, advocates, Medicaid participants receiving HCBS services, agencies that work with the targeted populations and state personnel. A question and answer period followed the presentation. Stakeholder questions and comments were documented. Stakeholders were specifically asked to provide feedback to the state on the following:

- Does their facility meet any of the CMS characteristics of a setting presumed to be an institution?
- If so, does that facility also meet the qualities of an HCBS setting?
- All stakeholders were asked to provide Medicaid with ideas on how facilities that meet the CMS characteristics of an institution might refute that presumed classification where appropriate. What evidence might be provided?
- If a facility does not meet the HCBS setting requirements, or if it will be presumed to be an institution, would the provider make changes to come into compliance?
- If so, how might a facility transition to full compliance and how long would it take?

Next, Medicaid developed a survey containing the following questions (based on guidance from CMS):

1. Is this setting in a publicly or privately owned facility providing inpatient treatment?
2. Is this setting on the grounds of, or immediately adjacent to, a public institution?
3. Does this setting have the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS?
 - a. Is this setting designed specifically for people with disabilities, and often even for people with a certain type of disability?
 - b. Are the individuals in this setting primarily or exclusively people with disabilities and on-site staff provides many services to them?
 - c. Is this setting designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services,

medical, behavioral and therapeutic services, and/or social and recreational activities?

d. Do people in this setting have limited, if any, interaction with the broader community?

e. Does this setting use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g., seclusion)?

Health facility surveyors from the RALF program were then asked to answer those questions for each RALF in Idaho. The six surveyors who participated each have between five and nine years of experience traveling throughout the state of Idaho to conduct licensing surveys and complaint investigations at all of the licensed residential care assisted living facilities in the state. The team conducts approximately 200 site visits per year, and each facility in the state undergoes a survey visit at least once every five years.

Surveyors did not find any RALFs in a publicly or privately owned facility providing inpatient treatment. They also did not find any on the grounds of, or immediately adjacent to, a public institution. However, 22 RALFs in Idaho were determined to be on the grounds of or immediately adjacent to a nursing home or hospital. Twelve of those RALFs are currently housing Medicaid participants. Idaho Medicaid understands that while these settings do not meet the criteria of settings presumed to be institutional an enhanced assessment may be necessary to ensure that these 12 RALFs are not institution-like settings and are not isolating residents.

Providers representing all the facilities identified above were invited to attend two conference calls with Medicaid staff. The goals for those calls were: 1) to educate providers about the new setting requirements and the criteria for settings presumed to be institutions as described in rule, and 2) to discuss options for ensuring that they are not institutional, do not isolate residents, and that the facility meets the requirements of an HCBS setting. Medicaid wanted to hear directly from the providers affected on what makes them different from an institution and the evidence providers believe they can provide to ensure they are not an institution-like setting. Ongoing communication from this group has been encouraged.

Finally, Idaho Medicaid determined that the questions used in the survey described above and answered by health facility surveyors are not sufficient to establish if a particular residential setting has the effect of isolation. As a result, Idaho's assessment of the settings against the third characteristic, settings that have the effect of isolating individuals from the broader community is not yet complete.

Analysis of Non-Residential Settings Presumed to be Institutional

As of the publication of the Transition Plan (v3), Idaho's assessment of non-residential HCBS settings against two of the characteristics of settings presumed to be institutional is complete. There are no non-residential HCBS settings that are in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. Below is a description of the assessment process that led to this conclusion.

Idaho's non-residential HCB services by definition must occur in a participant's private residence, the community, in developmental disabilities agencies (DDAs), or in standalone adult day health centers. A setting in a participant's private residence or the community is presumed to be compliant with all HCBS requirements. For the non-residential service setting analysis, DDAs and adult day health centers were the two setting types examined.

To assess the DDAs against the first two qualities of an institution, (in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution) Medicaid solicited the help of staff responsible for completing the licensing and certification of those settings. A list of all DDAs was created with two questions tied to the two above mentioned characteristics of an institutional setting. Licensing and certification staff who routinely visit those settings then answered the two questions about each specific DDA. No DDAs were found to be in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution.

To assess adult day health centers against those two characteristics, the Idaho Department of Health and Welfare staff responsible for the quality assurance activities for all standalone adult day health centers were asked to identify any centers in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution. No adult day health centers were found to be in a publicly or privately owned facility providing inpatient treatment or on the grounds of, or immediately adjacent to, a public institution.

Idaho will assess all settings against the third characteristic of an institution as part of its larger assessment effort in 2017. That characteristic is: Does this setting have the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS? Details of the assessment process are outlined in Section 2.

At this point in time Idaho does not intend to request the heightened scrutiny process for any HCBS setting.

Idaho Standards for Integration in All Settings

Idaho has worked extensively with providers, advocates, L&C staff and Medicaid staff to understand what qualifies as appropriate community integration in residential and congregate non-residential service settings.

Initially Idaho intended to create standards for integration for both residential and non-residential HCBS settings. The goal was to ensure that stakeholders, providers, quality assurance/assessment staff and participants, understood what must occur in HCB service settings to meet the integration and choice requirements of the new regulations. After many meetings with stakeholders, standards were determined for residential

settings. However, that task was much more of a challenge for non-residential service settings. The services themselves are variable and many are clinical in nature. Idaho organized a series of meeting with stakeholders to discuss what standards for non-residential service settings should be. Ultimately it was determined that instead of having fixed standards for integration, a toolkit will be developed for providers that includes guidelines, instructions for completing a self-assessment, review criteria and best practices for integration. The guidance will be incorporated into all trainings for staff and providers. It will also be incorporated into the setting assessment to be completed in 2017 and be part of ongoing monitoring of these settings. Attachments 1 and 2 have thus been removed from the Transition Plan (v3). It is the state's intention to ensure that any self-assessment tool or documents developed as part of the toolkit appropriately assess if participants are or are not given the opportunity for community participation to the extent that they desire and in manner that they desire in that setting.

Integration relies heavily on interaction with peers. It is the state's intention to define "peers" as including individuals with and without disabilities. The state will make this clear in administrative rules and in any guidance materials it provides.

1c. Gap Analysis of Non-Residential Service Settings

Idaho completed a preliminary gap analysis of its non-residential service settings in December 2014. The results of Idaho's analysis of its non-residential settings are summarized below, including an overview of existing support for each regulation. The state has included, where applicable, the full IDAPA rule citation(s) to identify where IDAPA supports the HCBS requirement, in addition to indicating if IDAPA is silent. The state did not identify any IDAPA rule that conflicts with the HCBS requirements. Additionally the chart includes preliminary recommendations to transition these settings into full compliance with the new regulations. Please note that the analysis of existing support for each new regulation is only the first step in the assessment process. It has been used to identify where Idaho lacks documented support for the setting quality requirements. Idaho understands that more work is necessary to complete a full assessment of settings. "Section 2: State Assessment and Remediation Plan" identifies the work remaining to complete a thorough assessment. That process includes soliciting input from participants receiving services, provider self- assessment, as well as on-site validation of compliance.

In summary, the state determined that there were gaps in support for some of the HCBS setting qualities for some of Idaho's non-residential services. Identified gaps included: lack of standards, lack of IDAPA support, and lack of oversight/monitoring to ensure compliance. Planned remediation activities include: development of standards to address congregate settings; development of standards to address access "to the same degree as individuals not receiving Medicaid HCBS;" rule promulgation to incorporate support for HCBS setting qualities into IDAPA; and enhanced monitoring and quality assurance activities to ensure ongoing compliance. A&D waiver services analyzed included: Supported Employment, Residential Habilitation, Day Habilitation, and Adult Day Health. These services may occur in Adult Day Health centers, Developmental Disability Agencies, or in the community. The table containing the non-residential service settings gap analysis is located at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=21>

Due to the gaps identified above, Idaho is unable to say at this time how many non-residential settings fully align with the federal requirements, how many do not comply and will require modifications, and how many cannot meet the federal requirements and require removal from the program and/or relocation of participants. Proposed plans to complete a full assessment are outlined in Section Two. Medicaid must first enact regulatory changes to allow enforcement and then complete the assessment of individual settings. The assessment will occur in 2017.

Services Not Selected for Detailed Analysis

Several service categories did not have gaps related to HCBS setting requirements. The state has determined that many of our HCBS services are highly medical/clinical in nature, self-directed, for the purchase of goods/adaptations, provided by providers who have no capacity to influence setting qualities, or occur in settings which are analyzed elsewhere in the Transition Plan. Therefore, for these services, a detailed analysis was not necessary.

This includes the following services:

- Chore Services
- Environmental Accessibility Adaptations
- Home Delivered Meals
- Personal Emergency Response System
- Skilled Nursing
- Specialized Medical Equipment and Supplies
- Non-Medical Transportation
- Homemaker
- Attendant Care
- Companion Services
- Consultation
- Respite

Section 2: State Assessment and Remediation Plan

The state is currently moving forward with regulatory changes in IDAPA to support the HCBS setting requirements. Rule changes are expected to become effective July 1, 2016, and providers will be given six months to become fully compliant. Idaho will begin its formal assessment of settings in January of 2017. It is expected to take one year. The state is not waiting until regulatory changes are enacted to

prepare staff, participants, and providers for the coming changes or for the assessment activities.

Tasks designed to assist the state in preparing for the assessment are currently underway and others will be completed in 2016. All tasks have been added to the current task lists found below. Activities include operational readiness tasks, materials development, staff training, and participant and provider training and communications, all of which will occur prior to the assessment start date of January 2017. In addition, there have been numerous training opportunities for providers to date and the HCBS regulations have been shared. Providers have the information they need to begin to make any needed changes to be compliant.

2a. Plan for Assessment and Ongoing Monitoring of Residential and Non-Residential Settings

Idaho Medicaid has developed a preliminary plan for assessment and ongoing monitoring of residential and non-residential settings where HCBS are delivered in order to ensure compliance with the new setting requirements. The proposed constellation of activities is a budget-neutral option that has been approved by Medicaid administration in collaboration with the Division of Licensing and Certification. The plan is divided into two stages: an initial assessment of residential and non-residential settings to determine their current level of compliance and an ongoing system of monitoring those settings to ensure continuous compliance. This approach employs a risk stratification methodology whereby all settings will be initially screened to assess initial compliance and to identify and address those settings most likely to have difficulty meeting the setting requirements. Those least likely to have difficulty meeting the setting requirements will be passively monitored to ensure compliance during the later stage of implementing monitoring activities. This proposal achieves a balanced approach to demonstrating compliance by phasing in cost-neutral changes that will minimize impact to existing Department operations while ensuring Idaho's HCBS participants have an experience that meets the intent of the HCBS regulations for integrated community living.

During the development of the initial assessment plan and plan for on-going monitoring, it was determined that additional resources were needed to effectively manage the proposed operational changes. A full-time position has been used to hire an HCBS coordinator to oversee all HCBS assessment and monitoring activities.

The state will establish an assessment and monitoring oversight committee. Membership on this committee is not yet finalized. This entity will meet with the HCBS Coordinator once a month beginning in August 2016. Responsibilities of the oversight committee will include problem solving for issues related to determination of non-compliance and/or termination of a provider agreement. This group will also be responsible to ensure participants wanting to transition to a new service provider are given the support they need to do so successfully. The committee will address any challenges to the proposed processes for assessment, monitoring, remediation, and/or needed process or program changes.

All RALFs and CFHs serving Medicaid HCBS participants are visited annually by Department staff. The state plans to incorporate assessment of HCBS compliance into the data that is collected during these visits as another mechanism of incorporating initial and ongoing assessment into our existing processes. In addition the state will visit a random sampling of RALFs and CFHs to complete an HCBS-specific compliance assessment during 2017 as part of the overall assessment process.

The assessment and monitoring plan also covers non-residential settings in which providers have the capacity to influence setting qualities. These provider types include:

- Adult Day Health Centers – 53 service sites
- Developmental Disability Agencies – 75 service sites
- Residential Habilitation Agencies – 82 service sites
- Supported Employment Providers – 33 service sites

Data collected during routine site visits, in conjunction with additional assessment information as described below, will be centrally warehoused to permit the Department to identify and cross-reference any trends or problems and will assist Idaho Medicaid in assessing initial and ongoing compliance of all settings. This multifaceted approach allows for a more robust mechanism of assessment than relying solely on one avenue for assessment.

One-Time Assessment

Idaho will implement a one-time assessment process to determine the initial level of compliance with the setting requirements by HCBS providers. That process will begin with the passage of state rule changes to support the HCBS regulations during the 2016 legislative session. Those rules are anticipated to become effective July 1, 2016, and providers will then be permitted six months to come into full compliance. The one-time assessment will be completed by December 2017. The assessment activities will include the following:

- Provider Self-Assessment
 - o A provider self-assessment will be sent electronically to all HCBS providers in July 2016. It will identify the HCBS requirements and request providers to identify if they are or are not currently complying with the requirements. If they are not currently compliant they will be asked to provide their plan for coming into full compliance, along with their timeline for doing so. Submission of a completed provider self-assessment will be mandatory. Providers will be given until August 31, 2016, to submit the completed document.

Full compliance is required by January 1, 2017. Training will be offered to providers prior to the self-assessment being sent out to address any questions providers may have. The training will also address how to develop an acceptable transition plan should their setting not yet be in compliance with the new setting requirements. The state will assess all submitted transition plans. The plan will either be approved or the state will work with the provider to revise it until it is deemed an acceptable plan. If the provider is unable or unwilling to create an acceptable plan to transition to full compliance, that provider will be moved into the remediation process.

- Validation of Provider Self-Assessment

- o Under the oversight of the HCBS Coordinator, quality assurance staff from the BDDS, Family and Children's Services (FACS), and the Bureau of Long Term Care (BLTC) will review provider self assessments that indicate the provider will need a transition plan to come into compliance. Staff will approve provider transition plans based on agreed upon criteria and follow up with the provider to ensure activities identified in the plan are completed on time.
- o Rule violations related to HCBS will be identified during existing quality assurance (QA) activity or through participant or Licensing and Certification complaints.
- o The Licensing and Certification staff members will be oriented to the HCBS setting qualities and will validate the provider self assessment during routinely scheduled Licensing and Certification surveys. The surveyors will continue to cite providers for violations of requirements that already exist under their purview using existing processes. If Licensing and Certification staff observe violations of other HCBS requirements, these will be reported to Medicaid QA staff to be investigated in the same fashion that other complaints are processed.
- o On-site HCBS-specific compliance reviews will be completed the first year of rule implementation on a representative sample of all HCBS providers. This will be a one-time activity to assist with transitioning existing providers to compliance.
- o New providers would be expected to comply at the time of Medicaid enrollment and HCBS requirements would be assessed at their six-month review.

- Acknowledgement of Understanding

- o Every service plan development process following rule promulgation in 2016 will include a discussion related to the setting requirements. The participant will be supplied with supporting information about the requirements, including a "These are Your Rights" document. As part of this process participants will also be informed that they can file a complaint if any of the requirements are not met and provided information on how to do so. Both the participant and the provider(s) responsible for implementing the service plan will then be asked to sign an acknowledgement that they have been informed of the new setting requirements and the participant's rights under these regulations. The QA staff will ensure signed documents are retained in the appropriate file using existing QA case file audit processes when applicable.

- Participant Feedback

- o Medicaid will modify existing participant experience measures in the Nurse Reviewer Home Visit Form to include questions that assess qualities of the participant's non-residential settings. Reported violations of HCBS setting requirements will be identified and investigated using the existing quality assurance protocols.
- o Feedback from participants will be reviewed as it becomes available from advocate groups and university research entities. Idaho Medicaid has been and will continue to work closely with the Idaho DD Council and the University of Idaho to support planned participant input activities to be led by the council. Currently the council is conducting face-to-face interviews with 240 participants to determine the existing level of compliance with HCBS requirements in the settings in which they reside and/or receive HCB services. This will serve as a baseline. The process will be repeated after Idaho completes its initial assessment in 2017 to determine, in part, implementation success. Any participant feedback collected in this manner will be provided to Medicaid in an electronic format that allows for data compilation and analysis.
- o Medicaid will develop an HCBS-specific participant survey that will be sent to a random sample of participants in January of 2017 asking them to assess the setting in which they are living and/or receiving HCBS against the HCBS requirements. All setting types will be included in the sample. This survey will allow Medicaid to receive feedback from participants regarding setting compliance with the non-residential setting requirements prior to the provider's routinely scheduled quality assurance or licensing review.

Ongoing Monitoring

The ongoing monitoring of non-residential settings for continuous compliance with the HCBS setting requirements will begin after the initial year of assessment, approximately January 1, 2018. It will continue indefinitely and will be modified as needed. Ongoing monitoring will include the following activities:

- Acknowledgement of Understanding

- o Each year during the person-centered planning process, the participant and provider(s) responsible for implementing the service plan will be asked to acknowledge their understanding of HCBS requirements. This will be monitored by QA staff using existing QA case file audit processes when applicable.

- Compliance Surveys and Quality Reviews

- o The L&C staff members will be oriented annually to the HCBS setting qualities. For those providers who require a certification (Developmental Disabilities Agencies (DDAs) and Residential Habilitation (ResHab) Agencies), L&C surveyors will continue to cite providers using existing processes for violations of requirements that already exist under their rule authority. If L&C observes violations of other HCBS requirements during routine L&C surveys, the violation will be reported to Medicaid QA staff to be investigated in the same fashion that other complaints are processed.
- o The BLTC QA staff will be oriented annually to the HCBS setting QA qualities. For those providers who receive regular provider quality reviews, QA staff will continue to cite providers using existing processes for violations.
- o The BLTC QA manager will assume responsibility for ongoing monitoring of non-residential setting qualities. They will ensure the following as part of the routine QA activities:

Complaints are addressed from participants, guardians or advocates, service coordinators, care managers, informal observations from bureau staff, or L&C staff regarding potential setting requirement violations using the existing complaints and critical incidents protocols.

Participant experience measures are reviewed to identify and investigate potential setting requirement violations via the same protocols as for other program requirement violations.

The QA staff from the alternate bureaus will communicate with each other on assessment and monitoring of HCBS setting qualities to ensure consistency and facilitate data collection.

- Participant Feedback

- o Medicaid will continue to use modified participant experience measures that include questions addressing setting qualities. As part of

ongoing monitoring, Medicaid may choose to further modify these measures as needed in order to target any identified statewide compliance concerns. This method will reach 100% of A&D Waiver participants each year.

- o Feedback from participants gathered by advocacy groups and university research entities will continue to be used, as it is available. Idaho Medicaid will continue to support these external efforts as much as possible. Any participant feedback collected in this manner will be provided to Medicaid in an electronic format that allows for data compilation and analysis.
- o Expanded HCBS-Specific Participant Survey: Each year Medicaid will identify potential areas of statewide compliance concerns and develop targeted questions to gather direct feedback from participants in those areas. Medicaid will send the Expanded HCBS-Specific Participant Survey to a random sample of participants as part of its monitoring activities for the first three years of implementation and then as needed based on information received through existing QA activities.

Any provider found to be out of compliance with the setting requirements during the initial assessment or the ongoing monitoring phase will go through an established provider remediation process. This process is to be defined as part of the detailed remediation plan which will be developed in 2016. If a rule violation is identified, action will depend on the severity. Action could range from technical assistance, a corrective action plan, or termination of a provider agreement. If it is determined that a setting does not meet HCBS requirements, participants receiving services in those settings will be notified and afforded the opportunity to make an informed choice of an alternative HCBS-compliant setting. The state will ensure that critical services and supports are in place in advance of and during the transition.

2b. Plan for Completing the Assessment of All Settings for Institutional Characteristics

Idaho has completed its assessment of all settings against the first two characteristics of an institution. There are no settings where an HCBS participant lives or receives services that are located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment. Further, there are no settings on the grounds of or immediately adjacent to a public institution. Idaho will assess all settings against the third characteristic of an institution as part of its larger assessment effort in 2017. At this point in time Idaho does not intend to request the heightened scrutiny process for any HCBS setting.

2c. Tasks and Timeline for Assessment of Residential and Non-Residential Settings

The state will conduct operational readiness work prior to beginning a formal assessment of residential and non-residential settings in 2017. The table containing the state's tasks and timeline for assessment of residential and non-residential settings can be found at: <http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=46>

2d. Tasks and Timeline for Assessment of Settings Presumed to be Institutional

The chart illustrating the tasks and timelines for assessment of settings presumed to be institutional is located at: <http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=51>

Major steps and timeline for moving to full compliance include:

- 1) Rule changes: completed by July 2016
- 2) Provider compliance period: completed by December 31, 2017
- 3) Assessment of compliance: beginning January 2017, completed by December 31, 2017
- 4) Provider remediation period: beginning as early as January 2017, anticipated completion early 2018
- 5) Provider sanctions or disenrollment: beginning as early as April 2017, anticipated completion early 2018
- 6) Relocation of participants as needed: beginning as early as April 2017, anticipated completion March 2019
- 7) Compliance period: beginning January 2017, completed by March 2019

The chart illustrating the major steps for coming into compliance with HCBS rules is located at: <http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=52>

2e. Plan for Provider Remediation

The state has hired an HCBS Coordinator to oversee all remediation activities. Idaho will also establish an Assessment and Monitoring Oversight Committee to support provider remediation activities. Idaho intends to complete a detailed remediation plan by March 2016. Idaho will publish the final remediation plan for public comment prior to the initiation of the assessment in 2017. However, below is a description of what the state currently plans to do in order to track and report on progress towards full compliance.

Any provider, residential or non-residential, found to be out of compliance with the setting requirements during the initial assessment or the ongoing monitoring phase will go through an established provider remediation process. This process is to be defined as part of the detailed remediation plan which will be developed in 2016. If a rule violation is identified, action will depend on the severity. Action could range from technical assistance, a corrective action plan, suspending payment of claims, or termination of a provider agreement.

The state is currently developing an HCBS-specific process with guidelines for enforcement of HCBS compliance. IDAPA 16.03.09.205.03 regulates agreements with providers and will be followed. The state anticipates establishing a tiered remediation process to allow providers ample opportunity for compliance and to allow the state time to support participants who choose to consider alternative, compliant providers.

The HCBS Program Coordinator is responsible for overseeing setting compliance and remediation activities. To do that, the coordinator will combine information from all assessment and monitoring activities which include:

- Results of HCBS-specific on-site assessments
- Provider self-assessment and transition plans
- Participant feedback received via the Participant Survey and feedback gathered by advocates
- Acknowledgement of Understanding documents to be signed by providers and participants
- Compliance surveys and reviews to be conducted by quality assurance staffs
- Corrective Action Plans
- Complaints received related to HCBS setting requirements

Section 2g includes a table with the known milestones and timelines for activities to specifically address remediation.

2f. Plan for Participant Transitions

Idaho Medicaid has a high-level plan on how the state will assist participants with the transition to compliant settings. The state will develop a more detailed relocation plan by March 2016. That plan will describe how the state will deliver adequate advance notice, which entities will be involved, how beneficiaries will be given information and supports to make an informed decision, and how it will ensure that critical services are in place in advance of the transition. Idaho will publish the final Relocation Plan along with the provider Remediation Plan for public comment prior to the initiation of the assessment in 2017.

All providers will have been assessed for compliance on the HCBS rules by the end of December 2017. Non-compliant providers will be given the opportunity to remediate any HCBS concerns. If a provider fails to remediate or does not cooperate with the HCBS transition, provider sanction and disenrollment activities will occur. Any provider who is unable or unwilling to comply with the new rules cannot be reimbursed by Medicaid to provide care and assistance to HCBS participants. If it is determined a setting does not meet HCBS setting requirements, participants will be notified in writing along with their person-centered planning teams. They will be advised that they have a minimum of six months to find alternative care or housing if desired. An updated person-centered plan will reflect whatever the participant chooses to do. They will be given information about the support available to assist them with this transition as well as alternative HCBS compliant settings. All choices will be documented in the participant's file.

2g. Tasks and Timeline for Remediation and Participant Transitions

The table containing the state's tasks and timeline for remediation and participant transitions can be found at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=55>

Section 3: Public Input Process

The public input process, including a summary of comments received during the state's prior public comment periods and responses to those public comments can be found at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=57>

Attachments

Attachment 1: Proof of Public Noticing (located at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=67>)

Attachment 2: Public Comments to the Idaho HCBS Settings Transition Plan Posted in October 2014 (located at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=102>)

Attachment 3: Public Comments to the Idaho HCBS Settings Transition Plan Posted in January 2015 (located at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=118>)

Attachment 4: Public Comments to the Idaho HCBS Settings Transition Plan Posted in September 2015 (located at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=140>)

Attachment 5: Index of Changes (located at:

<http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/HCBS/IDTransitionPlanV3Updated.pdf?ver=2015-10-23-104905-573#page=155>)

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 will engage in ongoing contract monitoring, and this includes performance monitoring of the MCE. This 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.aspx>

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	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services		

Function	Medicaid Agency	Contracted Entity
	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 has developed 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 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 State’s 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 Contract Monitor reviews every Issue that is entered into the Issue Log. 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 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 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	18	64	
	<input checked="" type="checkbox"/>	Disabled (Other)	18	64	
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	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. Appellant's 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 or Idaho Medicaid Plus 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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA 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 spenddown 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 five-year period beginning January 1, 2014, 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 December 31, 2018.

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

If a person:

1) Is not residing in adult residential care or a certified family home (CFH) and has a rent/mortgage obligation,
Then 180% of SSI single benefit rate plus the below personal needs allowances (PNAs) if there is enough income.

If a person:

1) Has no rent or mortgage obligation and is not married with a community spouse, or
2) Is residing in adult residential care or a CFH,
Then the SSI single benefit rate plus the following PNAs if there is enough income:

Personal Needs Allowances:

Persons with earned income. The PNA is increased by \$200 or the amount of their earned income, whichever is less. A greater PNA is needed to offset costs incurred in earning income.

Persons with taxes mandatorily withheld from unearned income for income tax purposes before the individual receives the income. A greater PNA 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 PNA 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 PNA 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 PNA is needed to offset impairment-related work expenses.

Income garnished for child support. Child support payments withheld from earned or unearned income due to a court order are considered "income garnished for child support". Such payments may increase the PNA if not already deductible from income under 42 CFR 435.726 (c) (3) for children living in the individual's home with no community spouse living in the home.

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:

If a person:

- 1) Is not residing in adult residential care or a certified family home (CFH) and has a rent/mortgage obligation, Then 180% of SSI single benefit rate plus the below personal needs allowances (PNAs) if there is enough income.

If a person:

- 1) Is married with a community spouse and does not live in adult residential care or a CFH, and does not have a

rent/mortgage obligation,
Then 150% of SSI single benefit rate plus the below PNAs if there is enough income.

If a person:

- 1) Has no rent or mortgage obligation and is not married with a community spouse, or
- 2) Is residing in adult residential care or a CFH,

Then the SSI single benefit rate plus the following PNAs if there is enough income:

Personal Needs Allowances:

Persons with earned income. The PNA is increased by \$200 or the amount of their earned income, whichever is less. A greater PNA is needed to offset costs incurred in earning income.

Persons with taxes mandatorily withheld from unearned income for income tax purposes before the individual receives the income. A greater PNA 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 PNA 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 PNA 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 PNA is needed to offset impairment-related work expenses.

Income garnished for child support. Child support payments withheld from earned or unearned income due to a court order are considered "income garnished for child support". Such payments may increase the PNA if not already deductible from income under 42 CFR 435.726 (c) (3) for children living in the individual's home with no community spouse living in the home.

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:

The allowance for individuals residing in the community who incur a rent or mortgage expense is being increased as the cost of these expenses in Idaho has outpaced the Social Security Cost of Living Adjustments (COLAs) over the last decade. This change will increase the amount of disposable income that participants retain after their Share of Cost to contribute towards their housing expenses.

- 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:

- 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 an entity 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.

- Total assistance with preparing or eating meals.
- Total or extensive assistance in toileting.
- Total or extensive assistance with medications which require decision making prior to taking, or assessment of efficacy after taking.

High Indicator - 6 Points Each.

- Extensive assistance with preparing or eating meals.
- Total or extensive assistance with routine medications.
- Total, extensive or moderate assistance with transferring.
- Total or extensive assistance with mobility.
- Total or extensive assistance with personal hygiene.
- Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI).

Medium Indicator - 3 Points Each.

- Moderate assistance with personal hygiene.
- Moderate assistance with preparing or eating meals.
- Moderate assistance with mobility.
- Moderate assistance with medications.
- Moderate assistance with toileting.
- Total, extensive, or moderate assistance with dressing.
- Total, extensive or moderate assistance with bathing.
- 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.

- One (1) or more critical indicators = Twelve (12) points.
- Two (2) or more high indicators = Twelve (12) points.
- One (1) high and two (2) medium indicators = Twelve (12) points.
- 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 State's quality improvement strategy, provide information in the following fields to detail the State's 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(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 420 (5 per Region, per month)
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 State's 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/>	<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

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 require 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		

Service Type	Service		
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		

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:

Service:

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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:

- Services provided in a facility must meet the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)."
- Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home".
- 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."
- 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"
- Adult day health providers who provide direct care or services must be free from communicable disease.
- 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:

04 Day Services ▼

Sub-Category 1:

04020 day habilitation ▼

Category 2:

▼

Sub-Category 2:

▼

Category 3:

▼

Sub-Category 3:

▼

Category 4:

▼

Sub-Category 4:

▼

Service Definition (Scope):

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:

08 Home-Based Services

Sub-Category 1:

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:

02 Round-the-Clock Services

Sub-Category 1:

02031 in-home residential habilitation

Category 2:

08 Home-Based Services

Sub-Category 2:

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 participant's 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:

09 Caregiver Support ▼

Sub-Category 1:

09011 respite, out-of-home ▼

Category 2:

09 Caregiver Support ▼

Sub-Category 2:

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 participant’s 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:

- Have received care giving instructions in the needs of the person who will be provided the service;
- Demonstrate the ability to provide services according to a plan of service;
- Be free of communicable diseases; and
- 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."
- 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:

- Have received care giving instructions in the needs of the person who will be provided the service;
- Demonstrate the ability to provide services according to a plan of service;
- Be free of communicable diseases; and
- 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."
- 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:

Service:

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

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 employer's 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:

08 Home-Based Services

Sub-Category 1:

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 participant's 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:**

02 Round-the-Clock Services ▼

Sub-Category 1:

02013 group living, other ▼

Category 2:

02 Round-the-Clock Services ▼

Sub-Category 2:

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:**08 Home-Based Services **Sub-Category 1:**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:

08 Home-Based Services

Sub-Category 1:

08040 companion

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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

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:

12 Services Supporting Self-Direction

Sub-Category 1:

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:

14 Equipment, Technology, and Modifications

Sub-Category 1:

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 participant’s principal residence, and is owned by the participant or the participant’s 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 Adaptations 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 Adaptations 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:

06 Home Delivered Meals

Sub-Category 1:

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:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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
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:

- Possess a valid driver's license;
- Possess valid vehicle insurance; and
- 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:

- Possess a valid driver's license;
- Possess valid vehicle insurance; and
- 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:

- Possess a valid driver's license;
- Possess valid vehicle insurance; and
- 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:**

14 Equipment, Technology, and Modifications

Sub-Category 1:

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 participant's 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:

- Rent or own a home, or live with unpaid caregivers;
- Are alone for significant parts of the day;
- Have no caregiver for extended periods of time; and
- 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:

05 Nursing ▼

Sub-Category 1:

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:

14 Equipment, Technology, and Modifications ▼

Sub-Category 1:

14032 supplies ▼

Category 2:

14 Equipment, Technology, and Modifications ▼

Sub-Category 2:

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 participant's 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: 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.

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, and skilled nursing.

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 provider's 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 participant's 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 & Children's 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 State's quality improvement strategy, provide information in the following fields to detail the State's 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):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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**

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Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 State's 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 result 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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, HCBS 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*):

- Registered nurse, licensed to practice in the State**
 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/Care Specialist 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 and Idaho Medicaid Plus 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 or Idaho Medicaid Plus enrollees, the Care Coordinator/Care Specialist 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/Care Specialist monitors the participant's service plan

and all waived 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 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 years service plan against services billed.
2. During the annual reassessment the nurse reviewer completes a Nurse Reviewer Home Visit in the participant's 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 State's quality improvement strategy, provide information in the following fields to detail the State's 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(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%; Confidence Level = 95%
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		+/- 5%; Confidence Level = 95%
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%; Confidence Level = 95%
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: MCE	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%; Confidence Level = 95%
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input style="width: 90%; height: 20px;" type="text"/>
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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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: MCE	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

- 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 participant's 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%; Confidence Level = 95%
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%; Confidence Level = 95%
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: MCE	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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:

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Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/- 5%; Confidence Level = 95%
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample

		Confidence Interval = +/- 5%; Confidence Level = 95%
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 and 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 is 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 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 State's 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 take responsibility for and accept 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 these 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:*

- 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 and skilled nursing 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	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Homemaker	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Attendant Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Consultation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Chore Service	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Waiver Service	Employer Authority	Budget Authority
Companion Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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 directs 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:

- Assist participant in verifying support worker citizenship status
 Collect and process timesheets of support workers

- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- 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	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Personal Emergency Response System	<input type="checkbox"/>
Residential Habilitation	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>
Environmental Accessibility Adaptations	<input type="checkbox"/>
Attendant Care	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Consultation	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
Day Habilitation	<input type="checkbox"/>
Non-medical Transportation	<input type="checkbox"/>
Chore Service	<input type="checkbox"/>
Adult Day Health	<input type="checkbox"/>
Companion Services	<input type="checkbox"/>
Adult Residential Care	<input type="checkbox"/>

- 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 and 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 reviews 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 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 days to select a provider-managed services 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 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

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority		
	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.
- 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 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 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. 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 the 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 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 MMCP 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:

- o The Right to be treated with dignity and respect.
- o The Right to choice of providers/caregivers/when services are provided.
- o 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, and 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 uses 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 is 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:

- o The Right to be treated with dignity and respect.
- o The Right to choice of providers/caregivers/when services are provided.
- o 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.

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 than 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 was distributed and discussed to 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, and 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.

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 and their roles in the 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 resident's 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:

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 State's quality improvement strategy, provide information in the following fields to detail the State's 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 instances of 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(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify: <input type="text"/>	
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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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: MCE	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: MCE	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: MCE	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 is 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 State's 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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 2)

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;
- 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 2)

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 <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input style="width: 300px; height: 20px;" type="text"/>	<input type="checkbox"/> Other Specify: <input style="width: 300px; height: 20px;" type="text"/>

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 Managers 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 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 pending 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 State's quality improvement strategy, provide information in the following fields to detail the State's 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):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = =

		+/- 5%, Confidence Level = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: MCE	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 State’s 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: MCE	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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 are made available for public review during regular business hours at any regional or field office of the Idaho Department of Health and Welfare and any regional or local public health district office. In Adams, Boise and Camas counties, copies of the amendments will be available at the county clerk's office in each of these counties. 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, Home Delivered Meal Services, and Chore Services. The initial rate was set in 1999 based on time studies in nursing facilities.

Consultation Services, Companion Services, Chore Services, Homemaker Services, Respite Care Services, Personal Emergency Response System Services, Residential Habilitation, Day Habilitation and Supported Employment - The initial rate was set 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.

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.

Attendant Care & 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 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.

- 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 State's 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.** *Select one:*

- 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 22 counties: Ada, Bannock, Bingham, Bonner, Bonneville, Boundary, 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 also part of a concurrent 1915(b)/(c) waiver for counties in which there are two or more participating health plans. The waiver portal does not permit the selection of multiple options under this subheader.

- 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.

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	7060.76	9674.00	16734.76	68174.00	8270.00	76444.00	59709.24
2	6357.02	9754.00	16111.02	70067.00	8684.00	78751.00	62639.98
3	6364.39	9834.00	16198.39	71961.00	9118.00	81079.00	64880.61
4	6357.14	9914.00	16271.14	73854.00	9574.00	83428.00	67156.86
5	6357.52	9994.00	16351.52	75747.00	10053.00	85800.00	69448.48

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
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 for these estimates is as follows:

Historical waiver expenditure data and user data from the 372 reports was used to assist in projecting forward the estimate for the five-year waiver period.

The estimated number of users of each service 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. Estimated units per user were held constant through the five years of the waiver renewal.

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.

- 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	

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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							181575.96
Adult Day Health MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	8	12.00	0.01	0.96	
Adult Day Health	<input type="checkbox"/>	Per 15 Minute Unit	90	1345.00	1.50	181575.00	
Adult Day Health Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
Day Habilitation Total:							27361.20
Day Habilitation	<input type="checkbox"/>	Per 15 Minute Unit	2	3020.00	4.53	27361.20	
Day Habilitation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	0	12.00	0.01	0.00	
Day Habilitation Idaho Medicaid Plus						0.00	
GRAND TOTAL:							81092870.18
Total: Services included in capitation:							218.16
Total: Services not included in capitation:							81092652.02
Total Estimated Unduplicated Participants:							11485
Factor D (Divide total by number of participants):							7060.76
Services included in capitation:							0.02
Services not included in capitation:							7060.74
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01		
Homemaker Total:							17401498.00
Homemaker MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	190	12.00	0.01	22.80	
Homemaker	<input type="checkbox"/>	Per 15 Minute Unit	6416	764.00	3.55	17401475.20	
Homemaker Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
Residential Habilitation Total:							2147796.24
Residential Habilitation	<input type="checkbox"/>	Per Diem	24	350.00	255.69	2147796.00	
Residential Habilitation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	2	12.00	0.01	0.24	
Residential Habilitation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
Respite Total:							90109.56
Respite	<input type="checkbox"/>	Per 15 Minute Unit	92	371.00	2.64	90108.48	
Respite MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	9	12.00	0.01	1.08	
Respite Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
Supported Employment Total:							37884.12
Supported Employment MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	1	12.00	0.01	0.12	
Supported Employment	<input type="checkbox"/>	Per 15 Minute Unit	8	902.00	5.25	37884.00	
Supported Employment Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
Attendant Care Total:							8759527.26
Attendant Care MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	173	12.00	0.01	20.76	
Attendant Care	<input type="checkbox"/>	Per 15 Minute Unit	1845	1205.00	3.94	8759506.50	
Attendant Care Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
Adult Residential Care Total:							45118296.16
Adult Residential Care	<input type="checkbox"/>	Per Diem	4913	248.00	37.03	45118240.72	
Adult Residential Care MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	462	12.00	0.01	55.44	
Adult Residential Care Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
Chore Service Total:							133228.68
Chore Service	<input type="checkbox"/>	Per 15 Minute Unit	332	152.00	2.64	133224.96	
Chore Service MMCP						3.72	
GRAND TOTAL:							81092870.18
Total: Services included in capitation:							218.16
Total: Services not included in capitation:							81092652.02
Total Estimated Unduplicated Participants:							11485
Factor D (Divide total by number of participants):							7060.76
Services included in capitation:							0.02
Services not included in capitation:							7060.74
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	<input checked="" type="checkbox"/>	Per Member Per Mo	31	12.00	0.01		
Chore Service Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
Companion Services Total:							2960366.73
Companion Services MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	48	12.00	0.01	5.76	
Companion Services	<input type="checkbox"/>	Per 15 Minute Unit	511	1689.00	3.43	2960360.97	
Companion Services Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
Consultation Total:							4854.48
Consultation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	11	12.00	0.01	1.32	
Consultation	<input type="checkbox"/>	Per 15 Minute Unit	122	5.20	7.65	4853.16	
Consultation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
Environmental Accessibility Adaptations Total:							85519.92
Environmental Accessibility Adaptations	<input type="checkbox"/>	Per Job	24	1.00	3563.32	85519.68	
Environmental Accessibility Adaptations MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	2	12.00	0.01	0.24	
Environmental Accessibility Adaptations Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
Home Delivered Meals Total:							2301965.46
Home Delivered Meals	<input type="checkbox"/>	Per Meal	2019	218.00	5.23	2301942.66	
Home Delivered Meals MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	190	12.00	0.01	22.80	
Home Delivered Meals Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
Non-medical Transportation Total:							227682.40
Non-medical Transportation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	88	12.00	0.01	10.56	
Non-medical Transportation	<input type="checkbox"/>	Per Mile	934	554.00	0.44	227671.84	
Non-medical Transportation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
Personal Emergency Response System Total:							503791.67
PERS Installation and 1st Month Rent	<input type="checkbox"/>	Per Month (+ Install)	335	1.00	56.89	19058.15	
PERS Monthly Rent	<input type="checkbox"/>	Per Month	1592	9.00	33.83	484716.24	
Personal Emergency Response System MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	144	12.00	0.01	17.28	
Personal Emergency Response System Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
GRAND TOTAL:							81092870.18
Total: Services included in capitation:							218.16
Total: Services not included in capitation:							81092652.02
Total Estimated Unduplicated Participants:							11485
Factor D (Divide total by number of participants):							7060.76
Services included in capitation:							0.02
Services not included in capitation:							7060.74
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled Nursing Total:							1039564.52
RN Nursing Services	<input type="checkbox"/>	Per 15 Minute Unit	131	33.00	10.19	44051.37	
LPN Nursing Services	<input type="checkbox"/>	Per 15 Minute Unit	111	619.00	7.31	502262.79	
Skilled Nursing MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	453	12.00	0.01	54.36	
Nursing Supervisory Visits	<input type="checkbox"/>	Per Visit	4840	2.00	50.95	493196.00	
Skilled Nursing Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies Total:							71847.82
Specialized Medical Equipment and Supplies MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	6	12.00	0.01	0.72	
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	Per Piece of Equipm	65	2.00	552.67	71847.10	
Specialized Medical Equipment and Supplies Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	0.00	0.01	0.00	
GRAND TOTAL:							81092870.18
Total: Services included in capitation:							218.16
Total: Services not included in capitation:							81092652.02
Total Estimated Unduplicated Participants:							11485
Factor D (Divide total by number of participants):							7060.76
Services included in capitation:							0.02
Services not included in capitation:							7060.74
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 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 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							169472.16
Adult Day Health MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	9	12.00	0.01	1.08	
Adult Day Health	<input type="checkbox"/>	Per 15 Minute Unit	84	1345.00	1.50	169470.00	
Adult Day Health Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	9	12.00	0.01	1.08	
Day Habilitation Total:							27361.20
Day Habilitation	<input type="checkbox"/>	Per 15 Minute Unit	2	3020.00	4.53	27361.20	
GRAND TOTAL:							75928247.85
Total: Services included in capitation:							499.56
Total: Services not included in capitation:							75927748.29
Total Estimated Unduplicated Participants:							11944
Factor D (Divide total by number of participants):							6357.02
Services included in capitation:							0.04
Services not included in capitation:							6356.98
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	0	12.00	0.01	0.00	
Day Habilitation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	12.00	0.01	0.00	
Homemaker Total:							16289576.88
Homemaker MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	197	12.00	0.01	23.64	
Homemaker	<input type="checkbox"/>	Per 15 Minute Unit	6006	764.00	3.55	16289473.20	
Homemaker Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	667	12.00	0.01	80.04	
Residential Habilitation Total:							1968813.60
Residential Habilitation	<input type="checkbox"/>	Per Diem	22	350.00	255.69	1968813.00	
Residential Habilitation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	2	12.00	0.01	0.24	
Residential Habilitation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	3	12.00	0.01	0.36	
Respite Total:							84234.12
Respite	<input type="checkbox"/>	Per 15 Minute Unit	86	371.00	2.64	84231.84	
Respite MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	9	12.00	0.01	1.08	
Respite Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	10	12.00	0.01	1.20	
Supported Employment Total:							33148.74
Supported Employment MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	1	12.00	0.01	0.12	
Supported Employment	<input type="checkbox"/>	Per 15 Minute Unit	7	902.00	5.25	33148.50	
Supported Employment Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	1	12.00	0.01	0.12	
Attendant Care Total:							8204047.20
Attendant Care MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	180	12.00	0.01	21.60	
Attendant Care	<input type="checkbox"/>	Per 15 Minute Unit	1728	1205.00	3.94	8204025.60	
Attendant Care Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	191	0.00	0.01	0.00	
Adult Residential Care Total:							42234759.36
Adult Residential Care	<input type="checkbox"/>	Per Diem	4599	248.00	37.03	42234640.56	
Adult Residential Care MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	480	12.00	0.01	57.60	
Adult Residential Care Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	510	12.00	0.01	61.20	
Chore Service Total:							124404.84
GRAND TOTAL:						75928247.85	
Total: Services included in capitation:						499.56	
Total: Services not included in capitation:						75927748.29	
Total Estimated Unduplicated Participants:						11944	
Factor D (Divide total by number of participants):						6357.02	
Services included in capitation:						0.04	
Services not included in capitation:						6356.98	
Average Length of Stay on the Waiver:						285	

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Chore Service	<input type="checkbox"/>	Per 15 Minute Unit	310	152.00	2.64	124396.80	
Chore Service MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	32	12.00	0.01	3.84	
Chore Service Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	35	12.00	0.01	4.20	
Companion Services Total:							2769195.42
Companion Services MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	50	12.00	0.01	6.00	
Companion Services	<input type="checkbox"/>	Per 15 Minute Unit	478	1689.00	3.43	2769183.06	
Companion Services Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	53	12.00	0.01	6.36	
Consultation Total:							4537.92
Consultation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	12	12.00	0.01	1.44	
Consultation	<input type="checkbox"/>	Per 15 Minute Unit	114	5.20	7.65	4534.92	
Consultation Idaho Medicaid Plus	<input type="checkbox"/>	Per Member Per Mo	13	12.00	0.01	1.56	
Environmental Accessibility Adaptations Total:							78393.64
Environmental Accessibility Adaptations	<input type="checkbox"/>	Per Job	22	1.00	3563.32	78393.04	
Environmental Accessibility Adaptations MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	2	12.00	0.01	0.24	
Environmental Accessibility Adaptations Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	3	12.00	0.01	0.36	
Home Delivered Meals Total:							2154913.44
Home Delivered Meals	<input type="checkbox"/>	Per Meal	1890	218.00	5.23	2154864.60	
Home Delivered Meals MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	197	12.00	0.01	23.64	
Home Delivered Meals Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	210	12.00	0.01	25.20	
Non-medical Transportation Total:							213068.80
Non-medical Transportation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	91	12.00	0.01	10.92	
Non-medical Transportation	<input type="checkbox"/>	Per Mile	874	554.00	0.44	213046.24	
Non-medical Transportation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	97	12.00	0.01	11.64	
Personal Emergency Response System Total:							473552.83
PERS Installation and 1st Month Rent	<input type="checkbox"/>	Per Month (+ Install)	349	1.00	56.89	19854.61	
PERS Monthly Rent	<input type="checkbox"/>	Per Month	1490	9.00	33.83	453660.30	
Personal Emergency Response System MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	150	12.00	0.01	18.00	
GRAND TOTAL:							75928247.85
Total: Services included in capitation:							499.56
Total: Services not included in capitation:							75927748.29
Total Estimated Unduplicated Participants:							11944
Factor D (Divide total by number of participants):							6357.02
Services included in capitation:							0.04
Services not included in capitation:							6356.98
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	166	12.00	0.01	19.92	
Skilled Nursing Total:							1032445.74
RN Nursing Services	<input type="checkbox"/>	Per 15 Minute Unit	136	33.00	10.19	45732.72	
LPN Nursing Services	<input type="checkbox"/>	Per 15 Minute Unit	116	619.00	7.31	524887.24	
Skilled Nursing MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	471	12.00	0.01	56.52	
Nursing Supervisory Visits	<input type="checkbox"/>	Per Visit	4531	2.00	50.95	461708.90	
Skilled Nursing Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	503	12.00	0.01	60.36	
Specialized Medical Equipment and Supplies Total:							66321.96
Specialized Medical Equipment and Supplies MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	6	12.00	0.01	0.72	
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	Per Piece of Equipm	60	2.00	552.67	66320.40	
Specialized Medical Equipment and Supplies Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	7	12.00	0.01	0.84	
GRAND TOTAL:							75928247.85
Total: Services included in capitation:							499.56
Total: Services not included in capitation:							75927748.29
Total Estimated Unduplicated Participants:							11944
Factor D (Divide total by number of participants):							6357.02
Services included in capitation:							0.04
Services not included in capitation:							6356.98
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 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 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							175524.78
Adult Day Health MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	9	12.00	0.01	1.08	
Adult Day Health	<input type="checkbox"/>	Per 15 Minute Unit	87	1345.00	1.50	175522.50	
Adult Day Health Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	10	12.00	0.01	1.20	
Day Habilitation Total:							27361.20
GRAND TOTAL:							79058426.68
Total: Services included in capitation:							545.16
Total: Services not included in capitation:							79057881.52
Total Estimated Unduplicated Participants:							12422
Factor D (Divide total by number of participants):							6364.39
Services included in capitation:							0.04
Services not included in capitation:							6364.34
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation	<input type="checkbox"/>	Per 15 Minute Unit	2	3020.00	4.53	27361.20	
Day Habilitation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	0	12.00	0.01	0.00	
Day Habilitation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	12.00	0.01	0.00	
Homemaker Total:							16940509.08
Homemaker MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	205	12.00	0.01	24.60	
Homemaker	<input type="checkbox"/>	Per 15 Minute Unit	6246	764.00	3.55	16940401.20	
Homemaker Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	694	12.00	0.01	83.28	
Residential Habilitation Total:							2147796.48
Residential Habilitation	<input type="checkbox"/>	Per Diem	24	350.00	255.69	2147796.00	
Residential Habilitation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	2	12.00	0.01	0.24	
Residential Habilitation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	2	12.00	0.01	0.24	
Respite Total:							87172.44
Respite	<input type="checkbox"/>	Per 15 Minute Unit	89	371.00	2.64	87170.16	
Respite MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	9	12.00	0.01	1.08	
Respite Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	10	12.00	0.01	1.20	
Supported Employment Total:							33148.74
Supported Employment MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	1	12.00	0.01	0.12	
Supported Employment	<input type="checkbox"/>	Per 15 Minute Unit	7	902.00	5.25	33148.50	
Supported Employment Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	1	12.00	0.01	0.12	
Attendant Care Total:							8526915.76
Attendant Care MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	188	12.00	0.01	22.56	
Attendant Care	<input type="checkbox"/>	Per 15 Minute Unit	1796	1205.00	3.94	8526869.20	
Attendant Care Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	200	12.00	0.01	24.00	
Adult Residential Care Total:							43924517.24
Adult Residential Care	<input type="checkbox"/>	Per Diem	4783	248.00	37.03	43924393.52	
Adult Residential Care MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	500	12.00	0.01	60.00	
Adult Residential Care Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	531	12.00	0.01	63.72	
GRAND TOTAL:							79058426.68
Total: Services included in capitation:							545.16
Total: Services not included in capitation:							79057881.52
Total Estimated Unduplicated Participants:							12422
Factor D (Divide total by number of participants):							6364.39
Services included in capitation:							0.04
Services not included in capitation:							6364.34
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Chore Service Total:							129621.84
Chore Service	<input type="checkbox"/>	Per 15 Minute Unit	323	152.00	2.64	129613.44	
Chore Service MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	34	12.00	0.01	4.08	
Chore Service Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	36	12.00	0.01	4.32	
Companion Services Total:							2879268.03
Companion Services MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	52	12.00	0.01	6.24	
Companion Services	<input type="checkbox"/>	Per 15 Minute Unit	497	1689.00	3.43	2879255.19	
Companion Services Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	55	12.00	0.01	6.60	
Consultation Total:							4736.82
Consultation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	12	12.00	0.01	1.44	
Consultation	<input type="checkbox"/>	Per 15 Minute Unit	119	5.20	7.65	4733.82	
Consultation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	13	12.00	0.01	1.56	
Environmental Accessibility Adaptations Total:							85520.16
Environmental Accessibility Adaptations	<input type="checkbox"/>	Per Job	24	1.00	3563.32	85519.68	
Environmental Accessibility Adaptations MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	2	12.00	0.01	0.24	
Environmental Accessibility Adaptations Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	2	12.00	0.01	0.24	
Home Delivered Meals Total:							2241566.00
Home Delivered Meals	<input type="checkbox"/>	Per Meal	1966	218.00	5.23	2241515.24	
Home Delivered Meals MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	205	12.00	0.01	24.60	
Home Delivered Meals Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	218	12.00	0.01	26.16	
Non-medical Transportation Total:							221601.36
Non-medical Transportation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	95	12.00	0.01	11.40	
Non-medical Transportation	<input type="checkbox"/>	Per Mile	909	554.00	0.44	221577.84	
Non-medical Transportation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	101	12.00	0.01	12.12	
Personal Emergency Response System Total:							492618.93
PERS Installation and 1st Month Rent	<input type="checkbox"/>	Per Month (+ Install)	363	1.00	56.89	20651.07	
PERS Monthly Rent	<input type="checkbox"/>	Per Month	1550	9.00	33.83	471928.50	
GRAND TOTAL:							79058426.68
Total: Services included in capitation:							545.16
Total: Services not included in capitation:							79057881.52
Total Estimated Unduplicated Participants:							12422
Factor D (Divide total by number of participants):							6364.39
Services included in capitation:							0.04
Services not included in capitation:							6364.34
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	156	12.00	0.01	18.72	
Personal Emergency Response System Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	172	12.00	0.01	20.64	
Skilled Nursing Total:							1070909.72
RN Nursing Services	<input type="checkbox"/>	Per 15 Minute Unit	142	33.00	10.19	47750.34	
LPN Nursing Services	<input type="checkbox"/>	Per 15 Minute Unit	120	619.00	7.31	542986.80	
Skilled Nursing MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	490	12.00	0.01	58.80	
Nursing Supervisory Visits	<input type="checkbox"/>	Per Visit	4711	2.00	50.95	480050.90	
Skilled Nursing Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	524	12.00	0.01	62.88	
Specialized Medical Equipment and Supplies Total:							69638.10
Specialized Medical Equipment and Supplies MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	7	12.00	0.01	0.84	
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	Per Piece of Equipm	63	2.00	552.67	69636.42	
Specialized Medical Equipment and Supplies Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	7	12.00	0.01	0.84	
GRAND TOTAL:							79058426.68
Total: Services included in capitation:							545.16
Total: Services not included in capitation:							79057881.52
Total Estimated Unduplicated Participants:							12422
Factor D (Divide total by number of participants):							6364.39
Services included in capitation:							0.04
Services not included in capitation:							6364.34
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 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 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							183594.90
Adult Day Health MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	10	12.00	0.01	1.20	
Adult Day Health	<input type="checkbox"/>	Per 15 Minute Unit	91	1345.00	1.50	183592.50	
Adult Day Health Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	10	12.00	0.01	1.20	
GRAND TOTAL:							82127890.46
Total: Services included in capitation:							569.16
Total: Services not included in capitation:							82127321.30
Total Estimated Unduplicated Participants:							12919
Factor D (Divide total by number of participants):							6357.14
Services included in capitation:							0.04
Services not included in capitation:							6357.10
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:							27361.20
Day Habilitation	<input type="checkbox"/>	Per 15 Minute Unit	2	3020.00	4.53	27361.20	
Day Habilitation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	0	12.00	0.01	0.00	
Day Habilitation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	12.00	0.01	0.00	
Homemaker Total:							17615851.20
Homemaker MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	213	12.00	0.01	25.56	
Homemaker	<input type="checkbox"/>	Per 15 Minute Unit	6495	764.00	3.55	17615739.00	
Homemaker Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	722	12.00	0.01	86.64	
Residential Habilitation Total:							2147796.72
Residential Habilitation	<input type="checkbox"/>	Per Diem	24	350.00	255.69	2147796.00	
Residential Habilitation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	3	12.00	0.01	0.36	
Residential Habilitation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	3	12.00	0.01	0.36	
Respite Total:							91090.32
Respite	<input type="checkbox"/>	Per 15 Minute Unit	93	371.00	2.64	91087.92	
Respite MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	10	12.00	0.01	1.20	
Respite Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	10	12.00	0.01	1.20	
Supported Employment Total:							37884.24
Supported Employment MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	1	12.00	0.01	0.12	
Supported Employment	<input type="checkbox"/>	Per 15 Minute Unit	8	902.00	5.25	37884.00	
Supported Employment Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	1	12.00	0.01	0.12	
Attendant Care Total:							8873499.54
Attendant Care MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	195	12.00	0.01	23.40	
Attendant Care	<input type="checkbox"/>	Per 15 Minute Unit	1869	1205.00	3.94	8873451.30	
Attendant Care Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	207	12.00	0.01	24.84	
Adult Residential Care Total:							45669375.76
Adult Residential Care	<input type="checkbox"/>	Per Diem	4973	248.00	37.03	45669247.12	
Adult Residential Care MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	519	12.00	0.01	62.28	
GRAND TOTAL:							82127890.46
Total: Services included in capitation:							569.16
Total: Services not included in capitation:							82127321.30
Total Estimated Unduplicated Participants:							12919
Factor D (Divide total by number of participants):							6357.14
Services included in capitation:							0.04
Services not included in capitation:							6357.10
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Residential Care Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	553	12.00	0.01	66.36	
Chore Service Total:							135240.00
Chore Service	<input type="checkbox"/>	Per 15 Minute Unit	337	152.00	2.64	135231.36	
Chore Service MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	35	12.00	0.01	4.20	
Chore Service Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	37	12.00	0.01	4.44	
Companion Services Total:							2995133.91
Companion Services MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	54	12.00	0.01	6.48	
Companion Services	<input type="checkbox"/>	Per 15 Minute Unit	517	1689.00	3.43	2995120.59	
Companion Services Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	57	12.00	0.01	6.84	
Consultation Total:							4935.84
Consultation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	13	12.00	0.01	1.56	
Consultation	<input type="checkbox"/>	Per 15 Minute Unit	124	5.20	7.65	4932.72	
Consultation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	13	12.00	0.01	1.56	
Environmental Accessibility Adaptations Total:							85520.40
Environmental Accessibility Adaptations	<input type="checkbox"/>	Per Job	24	1.00	3563.32	85519.68	
Environmental Accessibility Adaptations MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	3	12.00	0.01	0.36	
Environmental Accessibility Adaptations Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	3	12.00	0.01	0.36	
Home Delivered Meals Total:							2330498.96
Home Delivered Meals	<input type="checkbox"/>	Per Meal	2044	218.00	5.23	2330446.16	
Home Delivered Meals MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	213	12.00	0.01	25.56	
Home Delivered Meals Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	227	12.00	0.01	27.24	
Non-medical Transportation Total:							230377.68
Non-medical Transportation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	99	12.00	0.01	11.88	
Non-medical Transportation	<input type="checkbox"/>	Per Mile	945	554.00	0.44	230353.20	
Non-medical Transportation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	105	12.00	0.01	12.60	
Personal Emergency Response System Total:							512296.25
PERS Installation and 1st Month Rent	<input type="checkbox"/>	Per Month (+ Install)	377	1.00	56.89	21447.53	
GRAND TOTAL:						82127890.46	
Total: Services included in capitation:						569.16	
Total: Services not included in capitation:						82127321.30	
Total Estimated Unduplicated Participants:						12919	
Factor D (Divide total by number of participants):						6357.14	
Services included in capitation:						0.04	
Services not included in capitation:						6357.10	
Average Length of Stay on the Waiver:						285	

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PERS Monthly Rent	<input type="checkbox"/>	Per Month	1612	9.00	33.83	490805.64	
Personal Emergency Response System MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	162	12.00	0.01	19.44	
Personal Emergency Response System Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	197	12.00	0.01	23.64	
Skilled Nursing Total:							1114479.42
RN Nursing Services	<input type="checkbox"/>	Per 15 Minute Unit	147	33.00	10.19	49431.69	
LPN Nursing Services	<input type="checkbox"/>	Per 15 Minute Unit	125	619.00	7.31	565611.25	
Skilled Nursing MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	509	12.00	0.01	61.08	
Nursing Supervisory Visits	<input type="checkbox"/>	Per Visit	4900	2.00	50.95	499310.00	
Skilled Nursing Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	545	12.00	0.01	65.40	
Specialized Medical Equipment and Supplies Total:							72954.12
Specialized Medical Equipment and Supplies MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	7	12.00	0.01	0.84	
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	Per Piece of Equipm	66	2.00	552.67	72952.44	
Specialized Medical Equipment and Supplies Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	7	12.00	0.01	0.84	
GRAND TOTAL:							82127890.46
Total: Services included in capitation:							569.16
Total: Services not included in capitation:							82127321.30
Total Estimated Unduplicated Participants:							12919
Factor D (Divide total by number of participants):							6357.14
Services included in capitation:							0.04
Services not included in capitation:							6357.10
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 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 5

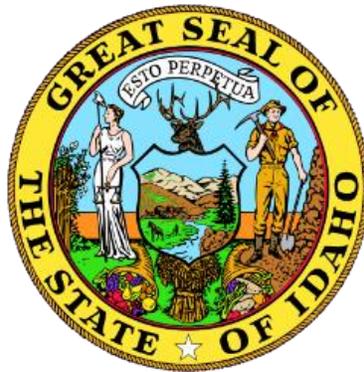
Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							189647.52
Adult Day Health MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	10	12.00	0.01	1.20	
Adult Day Health	<input type="checkbox"/>	Per 15 Minute Unit	94	1345.00	1.50	189645.00	
GRAND TOTAL:							85419686.55
Total: Services included in capitation:							589.80
Total: Services not included in capitation:							85419096.75
Total Estimated Unduplicated Participants:							13436
Factor D (Divide total by number of participants):							6357.52
Services included in capitation:							0.04
Services not included in capitation:							6357.48
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	11	12.00	0.01	1.32	
Day Habilitation Total:							41041.80
Day Habilitation	<input type="checkbox"/>	Per 15 Minute Unit	3	3020.00	4.53	41041.80	
Day Habilitation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	0	12.00	0.01	0.00	
Day Habilitation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	0	12.00	0.01	0.00	
Homemaker Total:							18321027.76
Homemaker MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	222	12.00	0.01	26.64	
Homemaker	<input type="checkbox"/>	Per 15 Minute Unit	6755	764.00	3.55	18320911.00	
Homemaker Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	751	12.00	0.01	90.12	
Residential Habilitation Total:							2237288.22
Residential Habilitation	<input type="checkbox"/>	Per Diem	25	350.00	255.69	2237287.50	
Residential Habilitation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	3	12.00	0.01	0.36	
Residential Habilitation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	3	12.00	0.01	0.36	
Respite Total:							95008.20
Respite	<input type="checkbox"/>	Per 15 Minute Unit	97	371.00	2.64	95005.68	
Respite MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	10	12.00	0.01	1.20	
Respite Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	11	12.00	0.01	1.32	
Supported Employment Total:							37884.24
Supported Employment MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	1	12.00	0.01	0.12	
Supported Employment	<input type="checkbox"/>	Per 15 Minute Unit	8	902.00	5.25	37884.00	
Supported Employment Idaho Medicaid Plus	<input type="checkbox"/>	Per Member Per Mo	1	12.00	0.01	0.12	
Attendant Care Total:							9224831.38
Attendant Care MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	203	12.00	0.01	24.36	
Attendant Care	<input type="checkbox"/>	Per 15 Minute Unit	1943	1205.00	3.94	9224781.10	
Attendant Care Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	216	12.00	0.01	25.92	
Adult Residential Care Total:							47496885.48
Adult Residential Care	<input type="checkbox"/>	Per Diem	5172	248.00	37.03	47496751.68	
GRAND TOTAL:							85419686.55
Total: Services included in capitation:							589.80
Total: Services not included in capitation:							85419096.75
Total Estimated Unduplicated Participants:							13436
Factor D (Divide total by number of participants):							6357.52
Services included in capitation:							0.04
Services not included in capitation:							6357.48
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Residential Care MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	540	12.00	0.01	64.80	
Adult Residential Care Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	575	12.00	0.01	69.00	
Chore Service Total:							140055.84
Chore Service	<input type="checkbox"/>	Per 15 Minute Unit	349	152.00	2.64	140046.72	
Chore Service MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	37	12.00	0.01	4.44	
Chore Service Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	39	12.00	0.01	4.68	
Companion Services Total:							3110999.91
Companion Services MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	56	12.00	0.01	6.72	
Companion Services	<input type="checkbox"/>	Per 15 Minute Unit	537	1689.00	3.43	3110985.99	
Companion Services Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	60	12.00	0.01	7.20	
Consultation Total:							5095.08
Consultation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	13	12.00	0.01	1.56	
Consultation	<input type="checkbox"/>	Per 15 Minute Unit	128	5.20	7.65	5091.84	
Consultation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	14	12.00	0.01	1.68	
Environmental Accessibility Adaptations Total:							89083.72
Environmental Accessibility Adaptations	<input type="checkbox"/>	Per Job	25	1.00	3563.32	89083.00	
Environmental Accessibility Adaptations MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	3	12.00	0.01	0.36	
Environmental Accessibility Adaptations Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	3	12.00	0.01	0.36	
Home Delivered Meals Total:							2423992.60
Home Delivered Meals	<input type="checkbox"/>	Per Meal	2126	218.00	5.23	2423937.64	
Home Delivered Meals MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	222	12.00	0.01	26.64	
Home Delivered Meals Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	236	12.00	0.01	28.32	
Non-medical Transportation Total:							239641.52
Non-medical Transportation MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	103	12.00	0.01	12.36	
Non-medical Transportation	<input type="checkbox"/>	Per Mile	983	554.00	0.44	239616.08	
Non-medical Transportation Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	109	12.00	0.01	13.08	
Personal Emergency Response System Total:							532939.55
GRAND TOTAL:							85419686.55
Total: Services included in capitation:							589.80
Total: Services not included in capitation:							85419096.75
Total Estimated Unduplicated Participants:							13436
Factor D (Divide total by number of participants):							6357.52
Services included in capitation:							0.04
Services not included in capitation:							6357.48
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
PERS Installation and 1st Month Rent	<input type="checkbox"/>	Per Month (+ Install)	392	1.00	56.89	22300.88	
PERS Monthly Rent	<input type="checkbox"/>	Per Month	1677	9.00	33.83	510596.19	
Personal Emergency Response System MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	168	12.00	0.01	20.16	
Personal Emergency Response System Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	186	12.00	0.01	22.32	
Skilled Nursing Total:							1159098.81
RN Nursing Services	<input type="checkbox"/>	Per 15 Minute Unit	153	33.00	10.19	51449.31	
LPN Nursing Services	<input type="checkbox"/>	Per 15 Minute Unit	130	619.00	7.31	588235.70	
Skilled Nursing MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	529	12.00	0.01	63.48	
Nursing Supervisory Visits	<input type="checkbox"/>	Per Visit	5096	2.00	50.95	519282.40	
Skilled Nursing Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	566	12.00	0.01	67.92	
Specialized Medical Equipment and Supplies Total:							75164.92
Specialized Medical Equipment and Supplies MMCP	<input checked="" type="checkbox"/>	Per Member Per Mo	7	12.00	0.01	0.84	
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	Per Piece of Equipm	68	2.00	552.67	75163.12	
Specialized Medical Equipment and Supplies Idaho Medicaid Plus	<input checked="" type="checkbox"/>	Per Member Per Mo	8	12.00	0.01	0.96	
GRAND TOTAL:						85419686.55	
Total: Services included in capitation:						589.80	
Total: Services not included in capitation:						85419096.75	
Total Estimated Unduplicated Participants:						13436	
Factor D (Divide total by number of participants):						6357.52	
Services included in capitation:						0.04	
Services not included in capitation:						6357.48	
Average Length of Stay on the Waiver:							285

**IDAHO MEDICAID MANAGED CARE QUALITY
STRATEGY:
Medicare Medicaid Coordinated Plan
Idaho Medicaid Plus**



Idaho Department of Health and Welfare, Division of Medicaid



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Section I: Introduction

Managed Care Overview, Goals and Objectives

History of Medicaid Managed Care in Idaho

The Idaho Department of Health and Welfare (IDHW) began to explore Medicaid managed care with the implementation of the Idaho Medicare Medicaid Coordinated Plan (MMCP) in 2006. The MMCP, under a Prepaid Ambulatory Health Plan agreement, coordinated Medicare Parts A and B benefits with certain outpatient Medicaid services for individuals dually eligible for Medicare and Medicaid. However, under this plan, a number of Medicaid benefits remained carved out and continued to be administered by the Division of Medicaid via a fee-for-service model, including inpatient services and Medicaid long-term services and supports (LTSS). The MMCP was a first step in integrating Medicare and Medicaid benefits for Idaho dual eligible individuals, even though these payer systems were not originally designed to work in tandem.

Since the launch of the MMCP in 2006, IDHW has engaged in other Medicaid managed care initiatives to better serve the population in Idaho in a cost-effective manner. The Patient Centered Medical Home (PCMH) model, which expanded February 2016, includes a tiered incentive structure for primary care providers to improve patient care and better coordinate services.

Idaho Medicaid also offers dental benefits and behavioral health benefits in managed care models under Prepaid Ambulatory Health Plans; the Idaho Smiles program and the Idaho Behavioral Health Plan both serve individuals with special health care needs that qualify for Enhanced Medicaid State Plan services.

MMCP Expansion

As a result of the passage of House Bill 260 in 2011, the Idaho Legislature directed Idaho Medicaid to develop a managed care program for the high-cost dual eligible population that would result in an accountable care system and improved health outcomes. Shortly thereafter, Idaho Medicaid began working with stakeholder groups to develop a comprehensive expansion to the existing MMCP that would better integrate Medicare and Medicaid benefits for Idaho's dual eligible population and introduce a new care management component. The Medicare and Medicaid systems were not initially designed to operate in an integrated fashion, oftentimes resulting in fragmented care, poor outcomes, and higher costs for the dual eligible population. The goal of the expanded MMCP is to increase access to comprehensive care within a care management model and improve health outcomes for participants whose benefits historically have not been well coordinated.

The Scope of Work (SOW) for the expanded MMCP was executed May 2014 and approved by the Centers for Medicare and Medicaid Services (CMS) in June 2014. The program launched in July 2014. The expanded MMCP, under a Managed Care Organization (MCO) contract, is a voluntary opt-in Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) available to individuals over age 21 that are eligible for Medicare Parts A and B and Medicaid. This plan is not available to those with Medicare eligibility due to having a diagnosis of End-Stage Renal Disease or those with limited Medicaid benefits.

IDHW looks forward to analyzing MMCP encounter data once it becomes available to determine if the MMCP results in cost savings and improved coordination of care for those duals that opt into the program.

Idaho Medicaid Plus

In order to offer dual eligible beneficiaries an improved service delivery system over Medicaid fee-for-service, Idaho Medicaid has developed a Managed Long-Term Services and Supports (MLTSS) program focused on the same population of individuals eligible to enroll in the MMCP. Idaho has applied for a §1915(b) waiver with a target effective date of October 1, 2018. The Idaho Medicaid Plus §1915(b) waiver will allow for a phased in mandatory Medicaid Managed Care Program for full dual-eligible individuals in counties where there are at least two participating health plans. Currently, there are two participating health plans in Ada, Bannock, Bingham, Bonner, Bonneville, Canyon, Kootenai, Nez Perce, and Twin Falls counties.

Idaho Medicaid's Quality Management Structure

The Bureau of Long Term Care (BLTC) is responsible for direct oversight of the MMCP and the Idaho Medicaid Plus program. QA staff within the Bureau operate under the supervision of the Quality Program Manager and are responsible for quality oversight of Idaho's Aged and Disabled 1915(c) waiver and State Plan Personal Care Services. Bureau Nurse Managers and Program Managers conduct internal file audits, while QA staff complete provider training and reviews and document and investigate Complaints and Critical Incidents relating to services under the purview of BLTC. A Contract Monitor within the BLTC maintains oversight of the MMCP and the Idaho Medicaid Plus quality assurance activities and reporting. Where there is overlap between MMCP activities, Idaho Medicaid Plus activities, and BLTC activities, such as the assessment for and delivery of long-term services and supports under Idaho's Aged and Disabled waiver, the Contract Monitor facilitates oversight activities.

At the Division level, the Central Office Management Team (COMT) maintains global oversight of all Medicaid activities, including quality assurance activities. COMT consists of the Bureau Chiefs in addition to the Administrator and Deputy Administrators of the Division of Medicaid.

The Medical Care Advisory Committee (MCAC) advises Idaho Medicaid in the development and refining of the overall Medicaid program by providing a sounding board and, as an advisory group, gives Idaho Medicaid feedback on current and evolving issues in Medicaid. Advocates, service providers, and public agencies strive to work together and share their experience and knowledge to maximize the care available to Idaho Medicaid participants. Membership is comprised of Medicaid participants and/or family/personal representatives, consumer groups on behalf of Medicaid participants and members of the general public who are concerned about health service delivery to the Medicaid population; healthcare professionals who serve the Medicaid population, and other individuals with relevant Medicaid knowledge and background in healthcare such as, but not limited to acute care, behavioral health, long term care, home care, Medicaid law and policy, healthcare financing, quality assurance, patient rights, health planning, and pharmacy care.

The Personal Assistance Oversight Committee (PAOC), a subcommittee of the MCAC, monitors and recommends changes to the Medicaid waiver and personal assistance programs. Such recommendations are submitted to the MCAC. The PAOC consists of providers of personal assistance services and participants of such services, advocacy organizations representing such participants, and other interested parties.

Development & Review of Quality Strategy (§438.202(b))

IDHW developed the quality strategy following the development and launch of the expanded MMCP and the subsequent development of the Idaho Medicaid Plus program. Stakeholders will be advised of the availability of the draft Quality Strategy during the MMCP and Idaho Medicaid Plus stakeholder webinar open to participants, providers, advocates, and other interested parties; stakeholders will also be notified at the Medical Care Advisory Committee, Personal Assistance Oversight Committee, and Tribal quarterly meetings. Once ready in draft form, the Quality Strategy will be posted for public feedback on the IDHW website dedicated to the MMCP. Stakeholders will be notified of the comment period via the same communication channels mentioned above and during statewide townhall meetings to be held in the spring of 2018.

The effectiveness of the Quality Strategy will be assessed annually and updated at that time if needed to reflect the current landscape of Idaho's Medicaid managed care programs. It will be updated more frequently should there be a significant change, which includes any expansion of the managed care model to other populations or programs or any amendments to the MMCP or Idaho Medicaid Plus SOW that result in a significant shift or expansion of the quality measurement protocols.

Section II: Assessment

Quality and Appropriateness of Care (§438.204(b)(1))

IDHW assesses the quality and appropriateness of care and services furnished to enrollees in the MMCP and the Idaho Medicaid Plus program by means of a robust constellation of contract monitoring and quality assurance activities. Participating Health Plans submit monthly, quarterly, and annual reports according to report specifications that are outlined in the SOW which address a variety of metrics. These reports for both programs include a grievance and appeals report, a complaint and critical incident tracking and resolution report, a denial of services report, a care coordination report, and a high-cost claimants report, among others. The Contract Monitor may request ad hoc reports and additional data if potential concerns regarding quality and appropriateness of care are identified. Complaints about quality or appropriateness of care and services furnished by the MMCP and the Idaho Medicaid Plus program that are received by the Division of Medicaid are tracked internally and investigated by the Contract Monitor. In addition, the Contract Monitor conducts quarterly on-site visits with the Health Plan, during which random sample file audits are completed. IDHW requests a corrective action plan when significant isolated or systemic quality and appropriateness of care issues are identified and validated.

Special health care needs are defined as any physical, developmental, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs beyond those typically required by the general population. The MMCP and Idaho Medicaid Plus programs serve only dually eligible Medicaid and Medicare beneficiaries; accordingly, the entire plan population consists of individuals who are elderly, disabled, or both. All enrollees fall into a continuum of special health care needs. Enrollee-specific needs are identified during the comprehensive health risk assessment or wellness assessment which must be completed within ninety (90) days of enrollment in the plan; enrollees are subsequently assigned a risk tier that dictates the minimum required frequency of contact with those persons in addition to the intensity of care management activities warranted by the individual's needs. This risk stratification is supplied to the IDHW monthly in a care coordination report. The IDHW Contract Monitor uses this report to cross-reference other data sources and identify any deficiencies in the Health Plan's performance with respect to serving customers across the entire spectrum of risk levels.

Race, Ethnicity, and Language Data (§438.204(b)(2))

Enrollee race, ethnicity, and primary language data is collected at the time of initial application and verified at ongoing annual reevaluation for Medicaid financial eligibility via the IDHW Division of Self Reliance. This data is entered into the Idaho Benefit Eligibility System (IBES) which is subsequently loaded into the MMIS during a nightly data transfer. This data is supplied to the Health Plan via a secured automated file transfer system upon enrollment into the plan. In addition, the Health Plan confirms this data during the comprehensive health risk assessment and wellness assessment process and accommodations are made as needed and as required by the SOW.

National Performance Measures (§438.204(c))

CMS has not identified any required national performance measures for Medicaid MCOs at this time. The IDHW is not currently collecting CMS or national core performance measures for the MMCP nor the Idaho Medicaid Plus program population. The Health Plans administering the programs, Blue Cross of Idaho Care Plus, Inc., and Molina Healthcare of Idaho are subject to Chapter Five – Quality Improvement Program of the Medicare Managed Care Manual. This includes a Chronic Care Improvement Program, a Quality Improvement Project, HEDIS Reporting, and CAHPS requirements. MMCP and Idaho Medicaid Plus enrollees are included in the overall population served by the Health Plan when collecting these data elements.

Monitoring and Compliance (§438.204(b)(3))

The Health Plans administering the MMCP and the Idaho Medicaid Plus program must comply with the Idaho Medicaid Provider Agreement terms in addition to the SOW Special Terms and Conditions that are specific to the administration of the MMCP and Idaho Medicaid Plus. The IDHW has specified within the SOW an array of performance thresholds, monitoring activities, and reporting requirements to ensure the Health Plans meet expectations as outlined in the agreement and the federal requirements for quality assessment and performance improvement described in 42 CFR 438 Subpart D. Reports required of the Health Plans include:

- *Provider Network Reports*
 - *Provider Enrollment File* (due annually). This report includes a list of current Medicaid-only service providers and their provider type/specialty.
 - *Geographical Access Report* (due annually). This report includes the number of network providers by type and specialty in each county. In addition, the report must indicate the percentage of Enrollees who have a PCP and behavioral health provider within thirty (30) miles of their residence for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock, and Bonneville counties; and forty-five (45) miles of their residence for all other counties in Idaho.
 - *Timeliness of Service Report* (due annually). This report includes the Health Plan's survey of its network providers, including the percentage of providers who have met the acceptable timeframe requirements identified in the Service Delivery Standards section of the SOW, any justification for providers that did not meet the access standard requirements, and any identified trends in providers that did not meet the standards.
 - *Assessment and Care Coordination Report* (due monthly). This report includes the number and percent of Enrollees with initial comprehensive health risk assessments and wellness assessments completed within thirty (30), sixty (60), and ninety (90) calendar days of initial enrollment, including the name and credentials of the staff person completing the assessment and the total number of Enrollees assigned to each Care Coordinator or Care Specialist.
- *Provider Payment Reports*
 - *Enrollment/Capitation Payment Reconciliation Report* (due monthly). This report identifies any Enrollees for whom a capitation payment has not been made or if an incorrect payment has been made.
 - *Provider Payment Report* (due quarterly). This report identifies (1) The percent of electronic clean claims paid within thirty (30) calendar days of receipt of the claim; (2) percent of electronic clean claims denied within thirty (30) calendar days of receipt of the claim; (3) percent of all electronic clean claims paid within ninety (90) calendar days of receipt of the claim; (4) percent of all electronic clean claims denied within ninety (90) calendar days of receipt of the claim; (5) percent of paper clean claims paid within forty five (45) calendar days of receipt of the claim; (6) percent of paper clean claims denied within forty-five (45) calendar days of receipt of the claim; (7) percent of all paper clean claims paid within ninety (90) calendar days; (8) percent of all paper clean claims denied within ninety (90) calendar days.
- *Utilization Management Reports*
 - *High-Cost Claimants Report* (due quarterly, only required for MMCP). This report details Enrollees who incurred non-nursing facility claims in excess of twenty-five thousand dollars (\$25,000). The report includes each Enrollee's age, sex, primary diagnosis, and amount paid by claim type for each identified Enrollee. The name and other identifying information about the Enrollee shall be blinded to maintain confidentiality. The report shall also detail all efforts made to ensure the Enrollee's services are coordinated,

communicated to the interdisciplinary care team, addressed in the Individualized Care Plan, and that the Enrollee is aware of and is participating in the appropriate disease management or case management services.

- *Aged and Disabled Waiver Utilization Report* (due monthly). This report includes a summary overview that details the number of Aged and Disabled Waiver Enrollees and Personal Care Services Enrollees, including the Enrollee's name, assigned identifiers, and secondary rate code when applicable. The report shall also include detailed Enrollee data for individuals who have not received service within the last thirty (30) calendar days, including service group, date of last long-term care service, length of time without long-term care services, and the reason why the Enrollee has not received services. Idaho Home Choice Money Follows the Person (IHCMFP) participants who are Enrollees will be identified separately for each data element.
- *Emergency Department Threshold Report* (due semiannually, only required for MMCP). This report identifies the number of Emergency Department visits by Enrollee by calendar month. The report also includes Enrollees with utilization exceeding ten (10) or more visits in a six (6) month period, in addition to the likely cause of the high utilization, the plan for those Enrollees to assist with reducing inappropriate utilization, and those Enrollees who were contacted by the Care Coordinator or PCP for the purposes of providing education on appropriate ED utilization.
- *Drug Utilization Report for Rebates* (due monthly). This report includes drug utilization data for all non-Part B and non-Part D drugs provided to Enrollees and includes information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed, including those drugs administered by physicians in their offices.
- *Provider Satisfaction with Utilization Management* (due annually). This report includes the results of a survey of Provider/office staff satisfaction with utilization management processes, a summary of areas identified for improvement, and the Health Plan's responses to areas identified for improvement.
- *Quality Management/Quality Improvement Reports*
 - *Aged and Disabled Waiver Consumer Direction of HCBS Report* (due quarterly). This report includes data pertaining to Aged and Disabled Waiver Enrollees who are enrolled in or referred for participation in self-direction of Home and Community Based Services (HCBS). Specific data elements are detailed in the SOW.
 - *Idaho Home Choice Money Follows the Person (IHCMFP) Participants Report* (due quarterly). This report includes data pertaining to Enrollees who are IHCMFP participants, including information on Enrollees who are in the process of transitioning into the community, such as claims details, living arrangement, services utilized, readmissions, etc. Specific data elements are detailed in the SOW.
- *Customer Service/Provider Service Reports*
 - *Call Center/Help Desk Report* (due quarterly). This report includes data regarding the number of calls received each month during the quarter, the types of calls received, and the timeframes for calls.

- *Nurse Advice Line* (due annually). This report details the number of calls received and call data regarding timelines, the types of calls received, and the dispositions of calls received.
- *Critical Incident Resolution Report* (due quarterly). This report includes data regarding critical incidents received during the quarter, including assigned priority levels, Enrollee information, and response timeframes and details.
- *Grievances, Appeals, and Complaints Report* (due monthly). This report includes data elements for all grievances, appeals, and complaints received by the Health Plan.
- *Fraud and Abuse Report – Involuntary Terminations and Fraud Activities Report* (due Quarterly). This report identifies any Health Plan Providers that are investigated or terminated for fraud or abuse, in addition to transition plans for Enrollees utilizing terminated providers.
- *Financial Management Reports.*
 - *Recovery and Cost Avoidance Report* (due quarterly). This report includes recoveries from third party resources as well as funds for which the Health Plan does not pay a claim due to third-party liability coverage.
 - *Other Insurance Report* (due quarterly). This report includes information regarding any Enrollees with other insurance, including long-term care insurance.
 - *Medical Loss Ratio Report.* (due monthly) This report includes all medical expenses and completed supporting claims lag tables.
 - *Medical Loss Ratio – Annual Report.* (due annually) This report includes the information required under 42 CFR §438.8 (k).
- *Claims Management Reports.*
 - *Claims Payment Accuracy Report* (due monthly). This report includes the results of the internal audit of a random sample of all paid claims for Medicaid services, indicating the number and percent of claims that are paid accurately.
 - *Claims Activity Report* (due monthly). This report includes the number of claims for Medicaid services received by the Health Plan, the number of claims denied, the number of claims paid, number of adjustments, and total dollar value of claims billed.
- *Information Systems Reports.*
 - *Systems Problem Report* (due within five (5) business days of the occurrence of a problem with system availability). This report details any issues with system availability and includes a plan that describes how the Health Plan will prevent the problem from recurring.
 - *Systems Availability and Performance Report* (due monthly). This report includes information on the availability and unavailability of major systems, including scheduled maintenance.
 - *Reporting on Controls at a Service Organization* (due annually). This report is a copy of an SSAE, SOC 1, Type II audit of the Health Plan performed annually.
 - *Contingency and Continuity Testing Report* (due annually). This report details the annual exercises conducted by the Health Plan to test current versions of information system contingency and continuity plans.

- *Administrative Requirements Reports.*
 - *Activities of the Member Advisory Group* (due semiannually). This report details the membership of the advisory group in addition to any orientation or ongoing training activities for advisory group members and minutes from each advisory group meeting.
 - *Service Denial Report* (due monthly). This report details all Enrollee Medicaid services denied through the Health Plan, including the number and type of requests denied, in addition to the reason for each denial.
- *HIPAA Report* (due quarterly). This report details any security incidents as defined by HIPAA, including the nature and scope of any incidents and the response to the incident.
- *Non-Discrimination Compliance Report* (due quarterly). This report details any complaints of discrimination filed against the Health Plan or the Health Plan’s employees, providers, or provider subcontractors in which discrimination is alleged as it relates to the provision of or access to Medicaid services provided by the Health Plan.
- *Specialized Services Reports.*
 - *FQHC, Rural Health Center, and Indian Health Clinic Report* (due quarterly). This report includes encounter data records documenting the Health Plan’s reimbursement to FQHCs, Rural Health Centers, and Indian Health Clinics.
 - *Developmental Disabilities (DD) Enrollee Details Report* (due quarterly, only for MMCP). This report documents a variety of data elements for MMCP Enrollees accessing DD waiver or State Plan services. Detailed report specifications can be found in the SOW.
- *Aged and Disabled Waiver Enrollee Service Plan Reports* (due quarterly). These reports include a variety of data elements for MMCP Enrollees accessing Aged and Disabled waiver services. Detailed report specifications can be found in the SOW.
- *Financial Accountability—Fraudulent Billing Report* (due annually). This report identifies service providers who had potentially fraudulent billing patterns that were investigated and actions taken by the Health Plan.

The IDHW contract monitor and other IDHW staff conduct monthly reporting meetings with the Health Plans to review report findings and request ad hoc reports when issues are identified or when additional data is desired to observe trends. In addition, the IDHW contract monitor conducts quarterly site visits to the Health Plan’s campus. During these quarterly visits, IDHW conducts a random sample file audit of the Health Plan’s case management system in order ensure compliance with standards for care coordination, timeliness of noticing, system requirements, etc.

In addition, IDHW believes in fostering a strong, positive working relationship with the Health Plans and maintaining an ongoing transparent dialogue. IDHW and the Health Plans conduct semi-annual statewide meetings with the public to encourage stakeholder feedback and solicit input regarding the program, in addition to providing education about the program. This approach to partnership and transparency has been invaluable in improving the experience of our customers and maintaining the integrity of the programs offered to duals.

External Quality Review (EQR) (§438.204(d))

The IDHW has contracted with Telligen, a healthcare consulting and care management organization, as the state Medicaid program's Quality Improvement Organization. The contract was signed in June of 2016 to include External Quality Review activities in relation to the Health Plan administering the MMCP for the September 2016 through August 2019 contract period. An amendment to the contract to include EQR activities for Idaho Medicaid Plus for the 2018-2019 contract year is expected to be executed in early 2018.

Telligen, performing as the External Quality Review Organization (EQRO) for the MMCP and Idaho Medicaid Plus, will conduct the mandatory EQR-related activities outlined in 42 CFR §438.358, including validation of performance improvement projects underway during the previous twelve months, validation of performance measures reported during the previous twelve months, and a review to determine the Health Plan's compliance with standards for access to care, structure and operations and quality measurement and improvement. The EQRO will not perform the optional EQR-related activities at 42 CFR §438.358(c). In addition, the EQR will not use information from Medicare or private accreditation reviews and the state will not exercise the non-duplication option under 42 CFR §438.360(c) because IDHW intends for the EQR to address the Medicaid-only components administered by the plan with respect to the mandatory EQR activities. Because the MMCP administered by the Health Plan is a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), the Health Plan is already subject to review as a Medicare Advantage Plan. In addition, the Medicare review activities are not substantially comparable to the State-specified mandatory activities.

Section III: State Standards

Standards for Access, Structure and Operations, and Measurement and Improvement as described in the Scope of Work for the MMCP and the Idaho Medicaid Plus program and established in operational protocols are described below.

Access Standards

Availability of Services and Assurances of Adequate Capacity and Services (42 CFR §438.206 and 42 CFR §438.207)

The IDHW ensures that the Health Plans' administration of the MMCP and the Idaho Medicaid Plus program meet the availability of services and capacity requirements described at 42 CFR §438.206 and 42 CFR §438.207. The MMCP SOW and the Idaho Medicaid Plus SOW contain provisions that address each requirement and the IDHW receives regular reporting on the Health Plans' provider networks and the availability of services for MMCP and Idaho Medicaid Plus Enrollees. The IDHW receives a quarterly provider enrollment file that specifies the number, type, and geographic distribution of the Health Plans' provider network. This data, in conjunction with enrollment information and risk tier distribution of the Enrollee population in each geographic area, permits the IDHW to determine whether the Health Plans' provider networks are robust enough to meet Enrollee needs.

On an annual basis, the Health Plans produce a geographic analysis of their provider networks to determine the percentage of Enrollees in Idaho's urban counties that have access to a provider within thirty (30) miles of their residence and the percentage of those Enrollees residing in rural counties that have access to a provider within forty-five (45) miles of their residence. The report distinguishes between provider types: primary care, emergency services, behavioral health services, and home and community-based services. The Health Plans also provide the results of their annual provider network survey, which is used to determine provider compliance with the required timelines for care and service delivery. The SOW requires that the Health Plans' provider networks be appropriate to meet the needs of the diverse MMCP and Idaho Medicaid Plus population and must ensure the availability of services 24-hours a day when medically necessary.

In addition, all Health Plan policies, procedures and provider subcontracts are reviewed and approved by the IDHW contract monitor and policy staff prior to implementation. Health Plan documents are submitted to a secure SharePoint site electronically for review. Documents are either approved and the approvals submitted back to the Health Plan, or are rejected and the Health Plan receives a notification indicating the reason for the rejection. This process ensures that Health Plan policies and procedures, network contracts, and other MMCP and Idaho Medicaid Plus documents comply with applicable state and federal requirements and assurances.

Coordination and Continuity of Care (42 CFR §438.208)

The IDHW requires the Health Plans to adhere to the coordination and continuity of care requirements of 42 CFR § 438.208. The MMCP and Idaho Medicaid Plus contain a Care Coordination element that functions as the hub of person-centered care delivery for MMCP Enrollees. To support a coordinated model of care, each Enrollee is assigned to a Care Coordinator upon enrollment in the MMCP. Beneficiaries that are enrolled into Idaho Medicaid Plus are assigned to a Care Specialist. The Health Plans administering the MMCP and Idaho Medicaid Plus receive an electronic eligibility file which includes rate code indicators for Enrollees – identifying those Enrollees who receive LTSS. This helps the Health Plan identify Enrollees with special health needs.

Under the MMCP, the Health Plans are required to assign Enrollees to a risk tier upon enrollment for the purposes of ensuring prompt outreach by a Care Coordinator. The Care Coordinator then conducts a face-to-face comprehensive health risk assessment with the Enrollee – in most cases, this occurs within 30 days of enrollment. Together with the Enrollee, the Care Coordinator develops an Individual Care Plan (ICP) that addresses a continuum of Enrollee needs, in addition to identifying the Enrollee's preferences for care delivery and their personal goals and desired outcomes. Enrollees are permitted a 90-day transitional period upon enrollment into the MMCP which allows them to keep their current providers of services even if they are out-of-network. The Care Coordinator assists the Enrollee in identifying in-network providers of services and in transitioning those services as smoothly as possible.

Under Idaho Medicaid Plus, Health Plans are also required to assign Enrollees to a risk tier upon enrollment. Because this program coordinates only the member's Medicaid services, the Care Specialist is not required to conduct a face-to-face wellness assessment. The wellness assessment must be

completed within 90 days of enrollment and Enrollees have a comparable 90-day transition period during which they can retain their current providers, even if they are out-of-network. Care Specialists are required to develop ICPs for Enrollees in Idaho Medicaid Plus.

The IDHW requires that the Health Plans make at least three attempts to contact an Enrollee to conduct a comprehensive health risk assessment or wellness assessment, and those contact attempts must be documented. For Enrollees who cannot be reached or who refuse to participate in a health screening or an assessment, the Care Coordinator or Care Specialist generates a basic care plan for the Enrollee and follows up in six months to offer Care Coordination services to the Enrollee again. The IDHW and Health Plans have determined that, for Enrollees accessing Medicaid LTSS through an HCBS waiver prior to their enrollment into the MMCP, collaboration between the IDHW Nurse Reviewer and the Health Plan Care Coordinator greatly improves the participation rate in Care Coordination. This model of collaboration will continue under the new Idaho Medicaid Plus program as well.

The ICP documents information about members of the Enrollee's Interdisciplinary Care Team (ICT) which includes, at minimum, the Enrollee and their Care Coordinator or Care Specialist, in addition to listing the Enrollee's primary care provider and contact information. If the Care Coordinator or Care Specialist identifies that the Enrollee has unmet medical or social service needs, or requires specialist services, he or she assists the individual in accessing those services. This can include benefits administered by the MMCP or Idaho Medicaid Plus in addition to community resources. The Care Coordinator or Care Specialist also works to identify any potentially duplicative services to streamline care delivery for the Enrollee.

The Health Plan utilizes an electronic care plan that becomes part of the Enrollee's health record. This electronic format has greatly facilitated both the collection and dissemination of health information when necessary to members of the Enrollee's ICT and has proven to be an excellent validation tool for monitoring efforts. The IDHW can easily assess the Health Plan's compliance with a number of SOW and federal requirements regarding Care Coordination and continuity of care by conducting a random sample file audit during on-site visits, which includes a review of ICPs.

The Health Plans are compliant with HIPAA requirements and provides copies of their HIPAA training materials and policies and procedures to the IDHW contract monitor annually for review.

Coverage and Authorization of Services (42 CFR §438.210)

The coverage offered under the MMCP includes those benefits under Medicare Parts A and B and the same benefits as are available under the Idaho Medicaid Enhanced Plan, in addition to benefits administered under Idaho's 1915(c) Aged and Disabled Waiver. The Health Plan is permitted to place appropriate limits on services based on medical necessity – a service is medically necessary if it is reasonably calculated to prevent, diagnose, or treat conditions in an Enrollee that endanger life, cause pain, or cause functionally significant deformity or malfunction; and there is no other equally effective course of treatment available or suitable for the Enrollee requesting the service which is more conservative or substantially less costly.

Coverage under the Idaho Medicaid Plus program includes the same benefits that are available under the Idaho Medicaid Enhanced Plan and the Aged and Disabled 1915(c) Waiver. The Health Plans are responsible for Coordination of Benefits (COB) for those benefits for which Medicare is the primary payer.

The IDHW ensures that the Health Plan processes initial and continuing authorizations for services in accordance with the SOW by reviewing and approving the Health Plan's policies and procedures for service authorization and by conducting a random sample file audit during on-site reviews. The IDHW also receives detailed information on all service denials issued by Health Plan monthly. This array of monitoring activities permits the IDHW to determine that the Health Plan makes authorization decisions within the required timeframes, and that any denials or authorization of services that are less than requested are made by appropriate personal and are not arbitrary decisions or made solely due to the diagnosis or type of illness of the Enrollee.

Structure and Operations Standards

Provider Selection (42 CFR §438.214)

The IDHW ensures that the Health Plans adhere to the provider selection requirements described at 42 CFR §438.214. Since the MMCP is a Medicare Advantage product, the Health Plan is also under the regulatory purview of Medicare credentialing requirements for those providers in its MMCP network furnishing Medicare-primary services. The Health Plan is required to implement a provider credentialing and re-credentialing system – and must submit its policies and procedures regarding this system to the IDHW annually or upon revision, whichever occurs first. The IDHW requires that the policies and procedures contain, at minimum, the following components:

- A training plan designed to educate staff in the credentialing and re-credentialing requirements;
- Provisions for monitoring and auditing compliance with credentialing standards;
- Provisions for prompt response and corrective action when non-compliance with credentialing standards is detected;
- A description of the types of Providers that are credentialed;
- Methods of verifying credentialing assertions, including any evidence of prior Provider sanctions;
- Prohibition against employment or contracting with Providers excluded from participation in federal health care programs; and
- Methods for certifying that each Provider license is current with the appropriate Idaho licensing bureau using the license and certification requirements for each individual Provider type.

The Health Plans may not discriminate against providers that serve high risk populations or specialize in conditions that require costly treatment. The IDHW receives a provider enrollment file on a quarterly basis that contains a listing by county of the providers in the Health Plan's MMCP and Idaho Medicaid Plus network, including provider type and specialty. The IDHW also receives a monthly report identifying

any providers investigated for potentially fraudulent billing patterns and any providers that were terminated. To date, the Health Plans have not terminated any MMCP provider of Medicaid-only services from its network. The IDHW requires that the Health Plans identify Enrollees that may be impacted by a provider termination to ensure that Enrollees are transitioned to other providers and continue to receive services.

Enrollee Information and Confidentiality (42 CFR §438.218 and 42 CFR §438.224)

The Bureau of Long Term Care, within the Division of Medicaid, provides information about the MMCP and the Idaho Medicaid Plus program to potential enrollees and enrollees to assist them when needed in understanding the program. The IDHW requires that the Health Plans make written material comprehensible and have a customer service line with language and format accessibility options available. The requirements for the Health Plan's customer service line, content and timeframe for notices, and minimum content required for the Enrollee Handbook meet the requirements of 42 CFR §438.218 and are described in detail in the SOW.

The Health Plans are compliant with HIPAA requirements and provide a copy of their confidentiality and HIPAA training materials and policies and procedures to the IDHW contract monitor annually for review.

Enrollment and Disenrollment (42 CFR §438.226)

Eligible Medicaid participants may voluntarily enroll or dis-enroll from the MMCP at any time, with or without cause. Both enrollment and disenrollment is prospective, with an effective date of the first of the calendar month following the request. The Health Plans are responsible for the following activities with respect to managing enrollments and dis-enrollments:

- Process all cancellations of voluntary enrollment.
- Process all voluntary enrollments.
- Process all voluntary dis-enrollments.
- Track information about all dis-enrollments.
- Ensure dis-enrollments requests received during any month are effective on the first calendar day of the following month.
- Cease the provision of Covered Services to an Enrollee upon the effective date of disenrollment.
- Notify the IDHW of any Enrollee who is no longer eligible to remain in the MMCP. This includes situations in which an Enrollee remains out of state or their residence in the state of Idaho cannot be confirmed for more than six (6) consecutive months.
- Transfer Enrollee record information promptly to any new provider upon written request by the Enrollee.
- Notify the IDHW if the Health Plan becomes aware that an Enrollee has comprehensive third-party insurance.

The Health Plans are prohibited from disenrollment of any Enrollee due to an adverse change in the Enrollee's health status or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. In specific

circumstances, the Health Plans are allowed to involuntarily dis-enroll an Enrollee. This includes when the Enrollee's enrollment impairs the Plan's ability to furnish services to that Enrollee or other Enrollees, if the behavior is unrelated to the Enrollee's health status or utilization of services. The Health Plans have a written policy and process regarding involuntary dis-enrollments which has been reviewed and approved by the IDHW. To process an involuntary disenrollment, the Health Plans must submit a request to the IDHW contract monitor, with evidence, of the reason for the involuntary disenrollment request. If approved, the Enrollee is disenrolled from the MMCP effective the first of the following calendar month and reverted to fee-for-service Medicaid and fee-for-service Medicare, unless they have chosen a Medicare Advantage plan, or if they reside in a county in which the Idaho Medicaid Plus program is available.

Eligible Idaho Medicaid Plus participants will have a 90-day open enrollment period in which they will have the opportunity to make an active selection of a participating Health Plan. If a member does not choose during the open enrollment period, the state will use an auto-assignment algorithm to assign the member to a participating Health Plan. Enrollees can choose to change Health Plans during the annual open enrollment period.

Enrollees may request reassignment to another Health Plan for cause at any time by contacting the IDHW – upon validation that the request meets criteria for good cause, the Enrollee will be enrolled with another participating Health Plan the month after the request is made. If an MMCP participant dis-enrolls from the MMCP, they will be automatically enrolled in the Idaho Medicaid Plus program with the same Health Plan they utilized under MMCP to minimize disruption of services, unless the Enrollee requests assignment to another Health Plan.

Grievance Systems (42 CFR §438.228)

The Health Plans' grievance and appeal system conforms to the requirements of 42 CFR §438.228. The IDHW requires that an Enrollee access the Health Plan's appeal system prior to filing a state Fair Hearing request. The Health Plan provides information to Enrollees regarding how to file a grievance or appeal in the Enrollee handbook, and aids with lodging complaints or filing appeals through the Care Coordinator or through its Customer Service line.

The IDHW monitors the Health Plans' Grievance and Appeals system in a variety of ways. The IDHW and Health Plans utilize a secure SharePoint site built to house real-time grievance and appeal information. This has proven to be a useful tool, particularly in managing appeals that reach the state Fair Hearing level and ensuring that information regarding an appeal is readily available for review. The IDHW also reviews notices distributed by the Health Plans, customer service line recordings, case management notes, and other sources of data during on-site visits with the Health Plans. This permits the IDHW to corroborate information on any grievance or appeal that has been logged on the SharePoint site.

Subcontractual Relationships and Delegation (42 CFR §438.230)

The Health Plans maintain oversight and are responsible for any functions and responsibilities they delegate to MMCP or Idaho Medicaid Plus subcontractor(s) in accordance with 42 CFR §438.230. All

contracts that the Health Plans utilize for subcontractors of MMCP or Idaho Medicaid Plus functions must be submitted for review and approval by the IDHW contract monitor and policy staff to ensure compliance with the SOW and applicable state and federal regulations.

Since the launch of the program, the Health Plans have demonstrated a proactive approach in monitoring the performance of subcontractors and in resolving subcontractor issues that may arise. Network providers are monitored by the Health Plans in the following ways:

- Review of the provider file against the list of excluded and sanctioned providers
- Review of the Medicare Opt Out Report, which is a listing of providers who have elected not to participate in the Medicare program for reimbursement
- Monitoring of the Board of Medicine and other state boards for licensure compliance and actions against providers taken by their boards or the court system
- Credentialing and Recredentialing processes
- Reviewing Grievance and Appeals data
- Routine audits to identify billing outliers, upcoding, unbundling, and other potential indicators of fraud, waste, or abuse.
- Provider Network Management and Provider Relations follow up on complaints from or by providers regarding billing practices, quality of services, treatment of members, access to care, and other complaints or concerns as raised as well as identifying other issues when reviewing reports looking for outliers.

The IDHW requires that the Health Plans notify the contract monitor in the event of a subcontractor being placed on corrective action. To date the Health Plans have not issued a corrective action request to an MMCP subcontractor.

Measurement and Improvement Standards

Practice Guidelines (42 CFR §438.236)

The Health Plans are required to operate and maintain practice guidelines under their Utilization Management (UM) Program that complies with the requirements at 42 CFR §438.236. The IDHW requires that the Health Plans' UM program guidelines be based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field that ensure decisions for utilization management, Enrollee education, and coverage of services are applied in accordance with these guidelines. In addition, the practice guidelines must:

- Consider the needs of enrollees
- Be adopted in consultation with providers
- Be reviewed and updated as appropriate
- Be disseminated to all affected providers, and upon request to Enrollees and Potential Enrollees in a manner that is accessible and understandable.

Quality Assessment and Performance Improvement Programs (42 CFR §438.240)

The Health Plans have robust quality management and quality improvement (QM/QI) programs. Both MMCP and Idaho Medicaid Plus comply with the requirements described at 42 CFR §438.240 for

Medicaid managed care plans. In addition, the MMCP complies with the requirements described in the Medicare Managed Care Manual and the National Committee on Quality Assurance (NCQA) Health Plan Accreditation requirements. The IDHW reviews the Health Plans' QM/QI programs on an annual basis during the External Quality Review process.

A component of the Health Plans' administration of the MMCP is the promotion of effective utilization of medical care, including the evaluation of potential overutilization and underutilization of services. The Health Plan's UM program includes prior authorization review for medical/surgical services and certain medications, identified outpatient behavioral health services, admissions and concurrent review for inpatient services and behavioral health admissions and rehabilitation, and discharge planning. The UM process is based upon appropriateness of care and service delivery, cost effectiveness, and existence of coverage.

The Health Plans are held to a high standard of performance for the MMCP. The IDHW reserves the right to monitor the performance of any aspect of the SOW and seek remedial action, not just those elements identified in the Performance Indicators below. Each Performance Indicator has been assigned an expected performance threshold and a timeframe for reporting data on each element. Criteria established are subject to change based on updated legal or policy mandates.

Performance Indicator	Threshold	Review Period
<p>Assessments Criteria:</p> <p>Reasonable efforts to complete Comprehensive Health Risk Assessments or Wellness Assessments within required timeframes (within ninety (90) calendar days of enrollment and at least once every twelve (12) months thereafter).</p>	95%	Quarterly
<p>The Individualized Care Plan shall be developed for each Enrollee no later than 120 calendar days from the time of enrollment or within 30 calendar days of the completion of the Comprehensive Health Risk Assessment, whichever occurs first.</p>	95%	Quarterly
<p>Call Standards</p> <p>Criteria:</p> <p>1) Percent of calls answered by a trained representative (non-recorded voice) within 30 seconds or less</p> <p>2) The average wait time for assistance does not exceed one hundred twenty (120) seconds.</p> <p>3) Call abandonment rate</p>	<p>Call Standards</p> <p>1) 80%</p> <p>2) The quarterly average must be less than or equal to one hundred twenty (120) seconds.</p>	Quarterly

<p>4) Percent of provider services helpline and call center/help desk staff trained to provide customer service response to inquiries.</p>	<p>3) <5% on average based on calls abandoned in the month divided by all incoming calls.</p> <p>4) 100%</p>	
<p>Claims Payment</p> <p>Criteria:</p> <p>1) Percentage of clean claims the Health Plan paid within thirty (30) calendar days of receipt</p> <p>2) Percentage of clean claims the Health Plan paid within ninety (90) calendar days of receipt</p>	<p>Claims Payment</p> <p>1) 90%</p> <p>2) 99%</p>	<p>Quarterly</p>
<p>Provide reports as outlined in the Reports/Records/Documentation Section and described in the Reporting Manual. Reports shall include data current through the respective reporting timeframe and shall be submitted within the required timeframe in the specified format.</p>	<p>100%</p>	<p>Quarterly</p>
<p>The Health Plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Enrollee.</p>	<p>100%</p>	<p>Quarterly</p>
<p>Ensure consistent with 42 CFR § 438.6(h), 42 CFR § 422.208 and 422.210, that compensation to individuals or entities that conduct Utilization Management (UM) activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.</p>	<p>100%</p>	<p>Quarterly</p>
<p>Advocacy for Enrollees</p> <p>The Health Plan shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, for the following:</p> <p>(i) The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.</p>	<p>100%</p>	<p>Quarterly</p>

<p>(ii) Any information the enrollee needs in order to decide among all relevant treatment options.</p> <p>(iii) The risks, benefits, and consequences of treatment or non-treatment.</p> <p>(iv) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.</p>		
Allow Enrollee self-direction of specified services through Personal Assistance Agencies (PAA) functioning as Fiscal Intermediary (FI) Agencies	100%	Ongoing
Adhere to managed care standards at 42 CFR § 438.214 and 42 CFR § 422.204, and shall be accredited or working toward accreditation by the NCQA and shall comply with procedural requirements for standards for credentialing and re-credentialing of licensed independent Providers and Provider groups with whom they contract, employ, who fall within their scope of authority and action, or with whom they have an independent relationship.	100%	Quarterly
Terminate, suspend, or deny enrollment to a Provider from its network as appropriate, and notify IDHW of such action immediately if a Provider is terminated or suspended from the Health Plan, Idaho Medicaid, Medicare, another state's Medicaid program, or is the subject of a State or Federal licensing Action or for any other independent Action.	100%	Quarterly
Maintain a network of Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees in the service area	100%	Ongoing
Implement and maintain policies and procedures to provide information, choice, and to enroll eligible Enrollees who consent to participate in the IHCMFP upon transition from a Qualified Institution to a Qualified Residence within the community	100%	Ongoing

Health Information Systems (42 CFR §438.242)

The Health Plan is required to maintain information technology (IT) systems that meet the requirements detailed in the SOW to ensure adequate capacity and infrastructure to administer the MMCP and Idaho Medicaid Plus. Blue Cross of Idaho's IT systems underwent extensive testing and improvement during the readiness review phase in 2014 prior to the expanded MMCP going live; Molina Healthcare of Idaho's systems similarly underwent extensive testing prior to that plan joining the MMCP in 2018. This included working closely with IDHW subject matter experts across a variety of areas to ensure that the Health Plan would be able to meet all the IT requirements established in the SOW. The Health Plan continues to make improvements to its IT systems to support the MMCP.

Prior to the implementation of Idaho Medicaid Plus, both Health Plans will undergo systems readiness testing to ensure accurate and timely transfer of eligibility and prior authorization data.

In addition, the Health Plans are required to collect ongoing data on their IT system performance, including system outages or file transmission issues, eligibility and enrollment information, claims data, Enrollee and provider characteristics, and information regarding services furnished to Enrollees. The IDHW receives this data from the Health Plans on a routine basis for monitoring purposes. This information includes, but is not limited to,

- An electronic file of all finalized encounter data, including those of its subcontractors, to the IDHW and/or its designee on all Medicaid State Plan and Waiver services rendered.
- A Provider Enrollment report on an annual basis identifying all providers in its network that may furnish services to MMCP and Idaho Medicaid Plus Enrollees.
- A Geographic Access Report and a Timeliness of Services Report, due annually, to quantify and demonstrate Enrollee access to the provider network.
- A daily 834 Benefit Enrollment and Maintenance transaction file (if new enrollments are available to process).
- A 270 eligibility request (if necessary).

Section IV: Improvement and Interventions

The MMCP is currently still in its nascent stages as an MCO; the expansion was launched July 2014 and the product is still in its early years of operations. During the first three years of the MMCP, IDHW and the Blue Cross of Idaho, which was the only participating Health Plan, worked collaboratively to establish uniform data collection and reporting functions, resulting in several amendments to the SOW over time. The purpose of the MMCP has been to test a new model of integrated service delivery for duals that is cost-neutral to the IDHW. Once the IDHW has complete encounter data, anticipated in summer 2018, the state will be able to identify additional opportunities for improvement with the MMCP model and to determine if better integrated care results in cost savings and improved quality of care for this population.

The MMCP has grown significantly in enrollment: approximately 600 enrollees were already enrolled in the previous PAHP MMCP, and enrollment in the expanded MMCP has grown to over 3,000 Enrollees across two participating Health Plans as of March 2018. This is, however, a comparatively small

population of the approximately 27,000 dual eligible individuals in Idaho. The initially small population has permitted extensive process improvement and collaboration with the Health Plan, as any identified issues can be remediated immediately with relatively little impact to Enrollees.

As a result of the successful implementation of the MMCP, IDHW is currently working towards phased-in implementation of the mandatory Idaho Medicaid Plus program for duals who have not enrolled in MMCP in counties where there are two or more participating Health Plans. IDHW intends to model all quality oversight of Idaho Medicaid Plus after the MMCP model.

Intermediate Sanctions (§438.204(e))

The IDHW Strategic Plan includes a goal of enhancing the delivery of health and human services, which applies across the spectrum of services and programs available under the purview of the Department. The goal of the MMCP and Idaho Medicaid Plus is to enhance the quality of services furnished to duals while containing costs for this complex population. In order to ensure the integrity and quality of the MMCP and Idaho Medicaid Plus, the IDHW has established a system of monitoring and oversight and a graded system of remediation when problems are identified.

The Contract Monitor issues a monthly monitor report that includes any identified SOW compliance issues from the previous reporting period. This report includes any applicable invoice reductions, as specified in the SOW. In the event of repeated or egregious noncompliance or quality issues, a corrective action plan is issued that requires a response from the Health Plan that describes in detail the steps it will take to remediate the problem and prevent it from recurring, in addition to a root cause analysis to identify what factors contributed to the identified issue. Invoice reductions may or may not be attached to a corrective action plan.

In the event that corrective action plans are insufficient to remediate an issue, the SOW has a detailed process for assessing liquidated damages. To date, the Health Plans' performance has not warranted this degree of action to correct a deficiency.

Optional temporary management may be imposed by IDHW if there is continued egregious behavior by a participating Health Plan including criteria described in 42 CFR § 438.700, behavior contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act, substantial risk to Enrollees' health, or if temporary management is necessary to ensure the health of Enrollees while improvements are made to remedy violations under 42 CFR § 438.700 or until there is an orderly termination or reorganization of the Health Plan.

IDHW must impose temporary management if it finds a Health Plan has failed to meet the substantive requirements in section 1903(m) or section 1932 of the Social Security Act in accordance with 42 CFR § 438.706 (b). IDHW will not delay imposition of temporary management to provide a hearing before imposing this sanction, nor will it terminate temporary management until it determines that the Health Plan can ensure that the sanctioned behavior will not recur. IDHW will notify Enrollees that temporary management has been imposed and of their right to disenroll.

Health Information Technology (438.204(f))

The IDHW has partnered with its MMIS provider, Molina Medicaid Solutions, to develop innovative ways of supporting the quality of the MMCP within the Medicaid information technology system. The compatibility and streamlining of data transmission between the IDHW and Health Plan's information systems has been critical to the success of the program. The IDHW has developed an automated weekly status report of all system interactions with the Health Plan system, which has allowed the state to identify potential impacts to Enrollees as a result of system errors. A monthly monitoring report was also developed that provides an aggregate of system interactions for the month, including eligibility data, capitation payment information, systems availability, file transmission records, etc. The IDHW also performs a quarterly audit on the Health Plan's information system. The IDHW has also recently developed a real-time system for monitoring Health Plan appeals/grievances that permits review of notices of action and additional documentation instantaneously. These improvements implemented over time will be carried over into the Idaho Medicaid Plus program.

This tiered system for monitoring and oversight of information technology operations has allowed for continual review and assessment of the operations of the information system against quality goals. In addition, the approach of a blended information system allows for a shared responsibility between the state and the Health Plan to support quality and access for MMCP enrollees.

Section V: Delivery System Reforms

The Idaho State Legislature directed Idaho Medicaid to develop a Medicaid managed care system for dual eligible individuals with House Bill 260 in 2011. The purpose in developing a managed care approach for the dual-eligible population is two-fold. First, the differing coverage rules between Medicaid and Medicare systems results in fragmented care and poor health outcomes for a population that has high needs. The Medicaid and Medicare funding streams were not designed to operate in tandem for individuals accessing both programs simultaneously, and varying reimbursement rates and methodologies can cause confusion for beneficiaries trying to navigate each system and can create conflicting financial incentives for providers.

Second, the dual-eligible population is historically a high cost group compared to other populations. Full duals comprise only 13% of the aggregate Medicare and Medicaid beneficiary populations, but they account for 34% of the total spending for both programs.¹ The IDHW intended to participate in the duals demonstration through CMS, but was unable to do so with only one interested Health Plan. Instead of entering into a three-way contract with CMS and the Health Plan, the IDHW entered into an MCO agreement with Blue Cross of Idaho to launch of a Fully Integrated Dual Eligible Special Needs Plan in July 2014. Molina Healthcare of Idaho joined the MMCP as a second participating Health Plan in January 2018.

The MMCP is available to full dual eligibles, defined as those individuals with full Medicaid benefits and Medicare Parts A and B. The program is not available to individuals that exclusively have Medicare Savings Program eligibility through Medicaid, such as the Qualified Medicare Beneficiaries (QMB) or Specified Low-Income Medicare Beneficiaries (SLMB). The program is also not available to individuals

who have Medicare eligibility as a result of having End-Stage Renal Disease. The state identifies full-duals who are potential Enrollees through the Idaho Benefit Eligibility System (IBES). IBES processes and warehouses eligibility data for Idaho Medicaid beneficiaries. An automated interface with the Social Security Administration feeds real-time data on Medicare eligibility into IBES, both when individuals age into Medicare or receive Medicare coverage due to disability. The eligibility information is then passed to the MMIS. The MMIS sends a monthly eligibility file that contains full dual eligible members to the Health Plans via the 834 file transmission process for outreach purposes to potential Enrollees. In addition, IDHW uses this eligibility data to track enrollment trends and to conduct targeted education and outreach meetings statewide.

The MMCP SOW specifies a number of performance measures that are specific to this population and are targeted at improving the quality of care furnished by the Health Plan. The IDHW established performance thresholds of 95% for completion of a Health Risk Assessment within 90 days of enrollment and completion of an Individualized Care Plan within 120 days of enrollment for new Enrollees and annually thereafter. The IDHW believes that care coordination is the foundation of improving care quality and health outcomes for duals. To date, the Health Plans have performed well on both measures.

Section VI: Transitions of Care

To facilitate transitions of care, the State makes its transition of care policy publicly available to Enrollees and potential Enrollees, including how to access continued services upon transition (42 C.F.R. § 438.62(b)(3)). The Health Plans are required to allow Enrollees to receive care from non-participating providers with whom an Enrollee has documented, established relationships for up to 90 days after enrollment. The Health Plans must make a good faith effort to subcontract with the non-participating provider and if a transition is necessary, shall facilitate collaboration between the non-participating provider and the new participating provider to plan a safe, medically appropriate transition in care.

The Health Plans are expected to screen 100% of institutionalized participants (residing in a Skilled Nursing Facility, Intermediate Care Facility for the Intellectually Disabled, or Institution for Mental Disease) for participation in the Idaho Home Choice Money Follows the Person program. This program is part of the federal Money Follows the Person Rebalancing Demonstration. The primary goal of this ten-year grant program is to facilitate the transition of Medicaid clients from nursing or other Long-Term Care facilities to the community using Home and Community Based Services (HCBS). Services are intended to promote independence, improve the transition process and support individuals in the community. Participants of the Idaho Home Choice program have access to qualified waiver services as well as demonstration services. They are enrolled in the program for up to 365 days, after which they enroll into an HCBS waiver, as long as they remain Medicaid eligible.

Section VII: Conclusions and Opportunities

The state experiences ongoing challenges and opportunities for improvement in the administration of the MMCP. The IDHW and Blue Cross of Idaho worked collaboratively over the first few years of the program to identify problems and improve reporting, communication, and systemic issues. While the voluntary enrollment structure resulted in a relatively small percentage of duals electing to enroll in the MMCP, this relatively small group of Enrollees has allowed the IDHW and Health Plan to remediate issues rapidly and tackle new or unforeseen problems effectively. In addition, the systems issues that inevitably occur with new or complex programs have been identified and corrected with minimal impact to Enrollees. The system error rate during the previously existing MMCP had a high average, but this average has been reduced to lower than 5% since the expansion of the MMCP in July 2014, due to increased monitoring and utilizing new mechanisms to hold the Health Plan accountable for performance. The IDHW and Health Plan have been able to remain vigilant of systems issues and to resolve any problems quickly due to the small population size. This has put the program in an excellent position to ensure that the system is operating smoothly if enrollment grows rapidly in the future.

Among the most significant lessons learned through this process is that having a strong, positive working dynamic between the Health Plan ultimately facilitates quality improvement and improving health outcomes for MMCP Enrollees. Maintaining an open and transparent line of communication between the IDHW and the Health Plan and an atmosphere of collaboration has fostered a philosophy of continuous quality improvement. The IDHW has established stringent oversight of quality for the administration of the MMCP, which has allowed for the evolution of mutual respect on behalf of both the IDHW and the Health Plan with roles clearly defined and executed. This established partnership also supported the onboarding of Molina Healthcare of Idaho, which joined the MMCP as a participating Health Plan in January 2018. The shared experience of IDHW and Blue Cross of Idaho over the early years of the program helped ensure a successful entrance into the market for Molina Healthcare.

Working together with the Health Plan to conduct semiannual statewide stakeholder outreach meetings has proven to be an effective tool to simultaneously gather feedback from the public about the program and to provide education and information to potential Enrollees. These statewide engagement forums have been the source of a number of improvements made over the last few years, including improving communication with providers and strengthening the coalition between the Health Plans and community networks of healthcare agencies to provide better care for Enrollees.

We believe that it is integral to the success of the MMCP and to improving health outcomes for the population. In September 2015, the IDHW Contract Monitor conducted a one-day site visit with the Care Management contractor for the Health Plan to observe the model in real-time. The state has used the information gleaned from this visit, in addition to research and dialogue with other states, to work with the Health Plan in improving the care management model. The visit also provided an opportunity to observe that the comprehensive health risk assessment did not meet the vision of the tool as intended – it was lengthy and cumbersome for participants. The IDHW and Health Plans have implemented more streamlined comprehensive health risk assessment requirements that improves customer experience with the process while obtaining only the relevant information needed for the participant's care plan.

The successes and challenges with the MMCP have paved the way for the implementation of Idaho Medicaid Plus with a projected go-live date of October 1, 2018. The mandatory enrollment model under Idaho Medicaid Plus will pose new challenges and opportunities, and we look forward to working with our participating Health Plans and federal partner to ensure a successful implementation for dual eligible Idahoans.

ⁱ See Congressional Budget Office, *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies* (Congressional Budget Office, June 2013).