IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
ALEX J. ADAMS – Director

JULIET CHARRON – Deputy Director
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

June 30, 2025

Deputy Director
Center for Medicaid and CHIP Services (CMCS)
Western Division – Regional Operations Group

Dear Deputy Director:

The State of Idaho is submitting a 1915(c) Home and Community Based Services (HCBS) Adult Developmental Disabilities waiver amendment in the federal WMS portal (ID.0076.R07.01).

This amendment focuses on updates to:

(a) Reimbursement changes from 2023 and 2024 Legislative Sessions.

(b) Language around the COVID-19 PHE Unwinding.

(c) HCBS Settings Final Rule Compliance.

(d) Provider Qualifications (to align with Fee Tables/IDAPA/Handbook better).

(e) Residential Habilitation contractor requirements.

(f) Technical updates to language around Restrictive Interventions, Service Plans, and Service Limitations.

These updates are consistent with Idaho Senate Bill S1456 (2024) and Idaho Senate Bill 1268 (2024).

The State Medicaid Agency is requesting an effective date of July 1, 2025.

Tribal solicitation and public notice were completed timely following our established procedures. We have included the details specific to the posting of the notices, distribution methods and tribal consultation in this submission packet. A Tribal Representative Notification Letter was mailed, e-mailed, and posted to the Medicaid-Tribes website on May 20, 2025, with a specified due date of June 20, 2025, for any feedback. Public notice was provided through the statewide process, with a draft copy of the waiver amendment, on dates between May 20, 2025, and May 23, 2025, with thirty (30) days for feedback.

Idaho appreciates your review of this proposed 1915(c) waiver amendment, and anticipates CMS approval. Please direct any questions to Charles Beal, Medicaid Policy Chief, at charles.beal@dhw.idaho.gov.

Sincerely,

JULIET CHARRON
Deputy Director

JC/cb

cc: Courtenay Savage

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May 20, 2025

Dear Tribal Representative:

In accordance with section 1902(a)(73)(A) of the Social Security Act regarding the solicitation of advice prior to the submission of any Medicaid or CHIP State Plan Amendment (SPA) or waiver application or amendment likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations, the Idaho Department of Health and Welfare (IDHW) Division of Medicaid (Idaho Medicaid) provides notice on the following matter.

Purpose

Idaho Medicaid intends to submit a Home and Community Based Services (HCBS) Adult Developmental Disabilities 1915(c) waiver amendment to CMS. This amendment focuses on updates to:

(a) Reimbursement changes from 2023 and 2024 Legislative Sessions.

(b) Language around the COVID-19 PHE Unwinding.

(c) HCBS Settings Final Rule Compliance.

(d) Provider Qualifications (to align with Fee Tables/IDAPA/Handbook better).

(e) Residential Habilitation contractor requirements.

(f) Technical updates to language around Restrictive Interventions, Service Plans, and Service Limitations.

These updates are consistent with Idaho Senate Bill S1456 (2024) and Idaho Senate Bill 1268 (2024).

These updates are in compliance with *42 C.F.R. § 430.25 Waivers of State plan requirements, 42 C.F.R. § 440.345 EPSDT and other required benefits, 42 C.F.R. § 440.386 Public notice, 42 C.F.R. §441.304 Duration, extension, and amendment of a waiver, 42 C.F.R. § 447.204 Medicaid provider participation and public process to inform access to care*, and *42 C.F.R. § 447.205 Public notice of changes in Statewide methods and standards for setting payment rates.*

Proposed Effective Date

The Department intends to submit these amendments to CMS with a requested effective date of January 1, 2025.

Anticipated Impact on Indians/Indian Health Program/Urban Indian Organizations

A. Does this change directly affect American Indians / Alaska Natives (AI/AN) or Indian Health Care Providers (IHCPs) but is federally or statutorily mandated?

Many of the changes are required by changes to state and federal laws. Changes may benefit both AI/AN participants and IHCPs.

B. Does the change impact services or access to services provided, or contracted for, by Indian Health Care Providers (IHCPs) including but not limited to:

- *Decrease/increase in services*
- *Change in provider qualifications/requirements*
- *Change service eligibility requirements (i.e. prior authorization)*
- *Place compliance costs on Indian Health Care Providers (IHCPs)*
- *Change in reimbursement rate or methodology*

Proposed updates do not increase or decrease available benefits. The changes to provider qualifications are to align the waiver with material already in the state administrative code and Provider Handbook. Proposed updates do not change requirements or service eligibility requirements (i.e. prior authorizations). It does not place compliance costs on IHCPs.

C. Does the change negatively impact or change the eligibility for, or access to, American Indians / Alaska Natives (AI/AN) Medicaid?

The proposed changes should not negatively impact eligibility for or access to services for American Indians / Alaska Natives (AI/AN).

Availability for Review

Copies of the draft pages are posted on the IDHW Policies, Procedures, and Waivers website (https://healthandwelfare.idaho.gov/about-dhw/policies-procedures-and-waivers) as follows:

- In the Waivers library (under “Medicaid waivers” PUBLIC-DOCUMENTS > For Providers > Medicaid > Waivers).

Comments, Input, and Tribal Concerns

Idaho Medicaid appreciates any input or concerns that Tribal representatives wish to share regarding these changes. Please submit any comments prior to **June 20, 2025,** by email addressed to MCPT@dhw.idaho.gov. The proposed amendment will also be reviewed as part of the Policy Update at the next Quarterly Tribal meeting.

Sincerely,

Juliet Charron
Administrator

JC/cb

NOTICE OF INTENT TO SUBMIT WAIVER AMENDMENT
AND SOLICITATION OF PUBLIC INPUT

Pursuant to 42 C.F.R. § 430.25 Waivers of State plan requirements, 42 C.F.R. § 440.345 EPSDT and other required benefits, 42 C.F.R. § 440.386 Public notice, 42 C.F.R. §441.304 Duration, extension, and amendment of a waiver, 42 C.F.R. § 447.204 Medicaid provider participation and public process to inform access to care, and 42 C.F.R. § 447.205 Public notice of changes in Statewide methods and standards for setting payment rates, the Idaho Department of Health and Welfare Division of Medicaid (Department) provides public notice of its intent to submit a waiver amendment to the Centers for Medicare and Medicaid Services (CMS).

PROPOSED CHANGES

Idaho Medicaid intends to submit a Home And Community Based Services (HCBS) Adult Developmental Disabilities 1915(c) waiver amendment to CMS. This amendment focuses on updates to:

(a) Reimbursement changes from 2023 and 2024 Legislative Sessions.
(b) Language around the COVID-19 PHE Unwinding.
(c) HCBS Settings Final Rule Compliance.
(d) Provider Qualifications (to align with Fee Tables/IDAPA/Handbook better).
(e) Residential Habilitation contractor requirements.
(f) Technical updates to language around Restrictive Interventions, Service Plans, and Service Limitations.

These updates are consistent with Idaho Senate Bill S1456 (2024) and Idaho Senate Bill 1268 (2024).

The Department intends to submit these amendments to CMS with a requested effective date of July 1, 2025.

ESTIMATE OF EXPECTED CHANGE IN ANNUAL AGGREGATE EXPENDITURES

There is no expected increase or decrease in annual aggregate expenditures.

PUBLIC REVIEW

Copies of the draft pages are posted on the IDHW Policies, Procedures, and Waivers website (https://healthandwelfare.idaho.gov/about-dhw/policies-procedures-and-waivers) as follows:

- In the Waivers library (under "Medicaid waivers" PUBLIC-DOCUMENTS > For Providers > Medicaid > Waivers).

Unless otherwise specified, copies are also available upon request for public review during regular business hours at any Regional Medicaid Services office of the Idaho Department of Health and Welfare.

LOCATIONS FOR PUBLIC REVIEW OF PROPOSED AMENDMENTS

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 Hiline, 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
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 the proposed waiver amendment for a period of at least thirty (30) calendar days. Any persons wishing to provide input may submit comments.

Comments must be received by the Department within thirty (30) days of the posting of this notice, and must be sent using one of the following methods:

- *Send Email Comments To:* MCPT@dhw.idaho.gov
- *Call and Leave Recorded Comments At:* (208)-364-1887
- *Send Fax Comments To:* 1-208-287-1170
- *Mail Comments To:* Division of Medicaid
  PO Box 83720, Boise, ID 83720-0009
  Attn: Policy Team
- *Hand Deliver Comments During Regular Business Hours (M-F from 8AM to 5PM, except holidays) To:*
  Division of Medicaid
  450 West State Street, 6th Floor, Boise, ID 83720
  Attn: Policy Team

The Department will review all comments received prior to submitting the waiver amendment to CMS.

PUBLIC HEARING

No public hearings have been scheduled at this time.

QUESTIONS

For technical questions or to review the changes, e-mail the request to MCPT@dhw.idaho.gov.

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Idaho Developmental Disabilities Waiver (renewal)

C. Waiver Number:nID.0076
Original Base Waiver Number: ID.0076.~~90.R07.00~~R07.00

D. Amendment Number:ID.0076.~~R076.02~~R07.01

E. Proposed Effective Date: (mm/dd/yy) 07/10/2025

Approved Effective Date:
Approved Effective Date of Waiver being Amended:

2. Purpose(s) of Amendment

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

Updates in this amendment include:

- Medicaid billing rate changes approved during the 2023 and 2024 Idaho Legislative Sessions.
- Public Health Emergency (PHE) Unwinding Updates.
- HCBS Settings Final Rule Compliance.
- Alignment of provider qualifications to match current Provider Enrollment parameters, Idaho Code, and published fee tables.
- Updates to Residential Habilitation contractor requirements.
- Technical updates to language around Restrictive Interventions, Service Plans, and Service Limitations

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☒ Waiver Application	
☐ Appendix A Waiver Administration and Operation	
☐ Appendix B Participant Access and Eligibility	
☒ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☒ Appendix I Financial Accountability	
☒ Appendix J Cost-Neutrality Demonstration	

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:

Update Public Health Emergency (PHE) unwinding activities.

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*):

Idaho Developmental Disabilities Waiver ~~(renewal)~~

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.0076
Waiver Number:
Draft ID:

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended:
Approved Effective Date of Waiver being Amended:

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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 purpose of this waiver is to provide an array of home and community-based services for eligible adults with developmental disabilities that encourage individual choice and independence, promote community integration, and prevent unnecessary institutionalization.

The key objectives of this waiver are:
• To allow eligible participants, who meet the Level of Care (LOC) required to receive services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), to choose between living in their home or other community-based setting (HCBS), or living in an institution;
• To require the use of a person-centered planning process to develop Service Plans and ensure that each participant's goals, needs and preferences are reflected in their respective plan;
• To assure that home and community-based services are provided by qualified and trained providers;
• To allow for participant-direction of home and community-based services; and
• To safeguard and protect the health and welfare of participants receiving home and community-based services under this waiver.

The waiver serves adults, age eighteen (18) or older, diagnosed with a developmental disability (DD) in accordance with Idaho Code § 66-402, and who can live safely in a non-institutional setting and, but for the provision of waiver services, would require institutionalization in an ICF/IID.

The waiver is administered and operated by the Idaho Department of Health and Welfare (Department) through its Bureau of Developmental Disability Services (BDDS) within the Division of Medicaid (Medicaid). The Department contracts with an Independent Assessment Contractor (IAC) to perform eligibility evaluations, including the completion of level of care (LOC) determinations and assignment of the individualized budget. Eligible participants may choose to receive either traditional waiver services or consumer-directed waiver services.

A. Traditional Waiver Services.
Participants who select traditional waiver services may facilitate their own person-centered planning meeting and write their person-centered Service Plan or designate a paid or non-paid Plan Developer to facilitate the meeting, write the Service Plan, or both. The costs for all paid supports identified on the participant's plan of service must not exceed the individualized budget assigned to them (except as modified by the Department for health, safety, or employment needs) for the upcoming plan year. In developing the plan of service, the person must identify paid and unpaid services and supports that can help them meet their desired goals. The Service Plan must identify: (1) type of paid and unpaid services to be delivered; (2) frequency of supports and services; (3) service providers; (4) service delivery preferences; (5) participant's HCBS setting preferences; (6) participant's strengths and preferences; (7) individually identified goals and desired outcomes; (8) risk factors and measures to minimize them; and (9) a Plan Monitor. In addition, the plan of service must include activities to promote progress, maintain functional skills, delay or prevent regression, and allow for health and safety.

Traditional waiver services are provided by approved Medicaid providers who bill directly through the Medicaid Management Information System (MMIS). The waiver makes the following traditional services available to eligible participants:
• Residential Habilitation either through Supported Living Services (in the home of the participant) or Certified Family Home Services (in the home of the provider);
• Respite Care;
• Supported Employment;
• Adult Day Health;
• Behavior Consultation/Crisis Management;
• Chore Services;
• Environmental Accessibility Adaptations;
• Home Delivered Meals;
• Non-Medical Transportation;
• Personal Emergency Response System;
• Skilled Nursing;
• Specialized Medical Equipment and Supplies; and
• Transition Services.

B. Consumer-Directed Waiver Services.
Participants selecting consumer-directed services must use a Support Broker (paid or unpaid) to assist with making informed choices, participate in the person-centered planning process, and become skilled at managing their own supports. The costs for all paid supports identified on the participant's plan of service must not exceed the individualized budget assigned (except as modified by the Department for health, safety, or employment needs) for the upcoming plan year. The plan of service must

identify: (1) type of paid and unpaid services to be delivered; (2) frequency of services; (3) service providers; (4) service delivery preferences; (5) participant's HCBS setting preferences; (6) participant's strengths and preferences; (7) individually identified goals and desired outcomes; (8) risk factors and measures to minimize them; and (9) a Plan Monitor. In addition, the plan of service must include activities to promote progress, maintain functional skills, delay or prevent regression, and allow for health and safety. Participants, who select consumer-directed services must use a Fiscal Employer Agent Medicaid provider to provide Financial Management Services (FMS) for payroll and reporting functions.
Review and approval of proposed plans of care, exception reviews regarding Supported Employment or health and safety concerns, and hearings to appeal a Department's decision regarding eligibility, ICF/IID LOC eligibility, budget calculation or Service Plan denial are handled by the Department.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

◉ **No**

○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the

procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

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

~~The Department solicited meaningful public input for this waiver~~ amendment ~~renewal application through the following outreach activitiesprocesses:~~

~~1. The Department emailed written notice of the anticipated waiver renewal to the designated tribal representatives of the six (6) federally recognized tribes in Idaho on April 25, 2022 and posted the notice to the Idaho Medicaid Program – Tribes website (https://healthandwelfare.idaho.gov/about-dhw/boards-councils-committees/idaho-medicaid-program-and-tribes-idaho). Idaho Tribes were given the opportunity to comment on the proposed waiver renewal for the period beginning April 25, 2022 through June 25, 2022. The proposed renewal was also reviewed as part of the Policy Update at the Quarterly Tribal meeting held on Wednesday, May 18, 2022.~~

~~2. On or before April 30, 2022, the Department published public notice of the proposed waiver renewal in newspapers of widest circulation in each Idaho city with a population of fifty thousand (50,000) or more and on the Department's website main page under "Public Notices and Hearings" (www.healthandwelfare.idaho.gov). Copies of the public notice and proposed waiver renewal were made available for public review on Department's website (www.healthandwelfare.idaho.gov) in the 1915(c) HCBS DD Waiver provider resources folder located at: https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=20850&dbid=0&repo=PUBLIC-DOCUMENTS on May 20, 2022 and during regular business hours at specified agency locations in each Idaho county. The state solicited feedback and comments on this proposed waiver renewal via mail, email, toll-free voicemail, fax, and in-person delivery for the period beginning April 25, 2022 through June 25, 2022 in the public notice.~~

Tribal solicitation and public notice were completed timely following our established procedures. We have included the details specific to the posting of the notices, distribution methods and tribal consultation in this submission packet. A Tribal Representative Notification Letter was mailed, e-mailed, and posted to the Medicaid-Tribes website on May 30, 2025, with a specified due date of June 30, 2025, for any feedback. Public notice was provided through the statewide process, with a draft copy of the waiver amendment, on dates between May 30, 2025, and June 1, 2025, with thirty (30) days for feedback.

~~3.~~ The Department did not receive written comments from tribal representatives or other public stakeholders.

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: Beal

First Name: Charles

Title: Medicaid Policy Director

Agency: Idaho Division of Medicaid

Address: P.O. Box 83720

Address 2:

City: Boise

State: **Idaho**

Zip: 83720-0009

Phone: (208) 364-1887 **Ext:** ☐ **TTY**

Fax: (208) 364-1811

E-mail: Charles.Beal@dhw.idaho.gov

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

Last Name: Charron

First Name: Juliet

Title: Medicaid Administrator

Agency: Department of Health and Welfare - Division of Medicaid

Address: P.O. Box 83720

Address 2:

City: Boise

State: **Idaho**

Zip: 83720-0009

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

Fax: (208) 364-1811

E-mail: juliet.charron@dhw.idaho.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: ~~Jennifer Pinkerton~~

State Medicaid Director or Designee

Submission Date: ~~Mar 3, 2023~~

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

Last Name: Charles

First Name: Beal

Title: Medicaid Policy Director

Agency: Department of Health and Welfare - Division of Medicaid

Address: P.O. Box 83720

Address 2:

City: Boise

State: **Idaho**

Zip: 83720-0009

Phone: (208) 364-1887 **Ext:** ☐ **TTY**

Fax: (208) 364-1811

E-mail: charles.beal@dhw.idaho.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

Not applicable.

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.

N/A

~~The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition~~

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

1. American Rescue Act (ARP) Program Improvements.
The state has a spending plan approved by CMS related to Section 9817 of the ARP Program.

Effective for the period of July 1, 2022, through ~~June 30, 2023~~January 30, 2024, the state used ~~will use~~ reinvestment funding to enhance provider rates for certain Home and Community Based Services (HCBS) provider types. The following high-level summary describes the projects conditionally approved in Idaho's submitted spending plan. More information about the state's ARP implementation is available on the Department's public website in the American Rescue Plan (ARP) public document library (https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=18732&dbid=0&repo=PUBLIC-DOCUMENTS).

Project 1: Developmental Disability Agency (DDA) Rate Increases.
ARP HCBS funding supported rate increases for four (4) services billed by DDAs. The Adult Day Health service (procedure code S5100) under this waiver authority and three (3) services under the 1915(i) Adult Developmental Disabilities (DD) state plan benefit. Rate increase methodology was based on a cost survey of all DDA providers.

~~Project 2: Personal Assistance Agency (PAA) Rate Increases.~~
~~ARP HCBS funding supported rate increases for six (6) services billed by PAAs. Five (5) of these services fall under the 1915(c) Aged and Disabled (A&D) waiver authority and the other (Personal Care Services) falls under the state's Medicaid Enhanced State Plan Alternative Benefit Plan (ABP) and the Medicare Medicaid Coordinated Plan ABP. There are no applicable services provided by PAAs on this waiver authority.~~

~~Project 3: Residential Assisted Living Facility (RALF) Rate Increases.~~
~~ARP HCBS funding supported changes to the Bureau of Long Term Care's (BLTC) Uniform Assessment Instrument (UAI) used to authorize care time for certain participants in a RALF setting. There are no RALF providers on this waiver authority.~~

Project 24: Residential Habilitation (ResHab) Agency Rate Increases.
ARP HCBS funding supported rate increases for four (4) services billed by ResHab Agencies. All four (4) services fall under this 1915(c) waiver authority. Applicable services on this waiver for this project include the following Supported Living rate codes: H2015, H2015 (HQ), H2022, and H2016. Rate increase methodology was based on an updated cost survey from an initial cost survey completed by ResHab providers in 2018.

Project 3: Certified Family Home Rate Increases
ARP HCBS funding supported changes to increase CFH rates by increasing the allowable amount for rate code S5140. Rate increase methodology was based on an application of an inflation calculator to established rates.

Project 4: Supported Employment Services (SES) Rate Increases
ARP HCBS funding supported changes to one (1) procedure code billed by SES. The service falls under this 1915(c) waiver authority. Applicable services on this waiver for this project include: H2023. Rate increase methodology was based on an application of an inflation calculator to established rates.

Project 5: Home Delivered Meals Rate Increases
ARP HCBS funding supported changes to one (1) procedure code billed by Home Delivered Meal providers. The service falls under this 1915(c) waiver authority. Applicable services on this waiver for this project include: S5170. Rate increase methodology was based on an application of an inflation calculator to established rates.

2. Public Health Emergency (PHE) Unwinding Activities~~.~~
The state has completed ~~not yet started~~ unwinding activities related to the COVID-19 public health emergency (PHE) and approved ~~related flexibilities authorized~~ through the Appendix K amendment authorities~~for this waiver~~. Appendix K authorities expired on November 11, 2023. In addition to ongoing stakeholder meetings, the State also provided the following guidance for reference:~~All temporary PHE rate increases have been phased out of the currently approved Appendix K, however are now permanently paid at a rate higher than the PHE temporary rate, as indicated in Appendix J.~~

a. The State published Frequently Asked Questions (FAQ) for providers and participants on the public website prior to the end of the declaration ending the PHE on May 11, 2023. These websites provide information on all of the flexibilities included in the State's 1135 and Appendix K emergency waivers during the pandemic. FAQs include:

- Medicaid and the Federal Public Health Emergency (https://healthandwelfare.idaho.gov/medicaid-and-federal-public-health-emergency) – this page is for participants and the general public. This FAQ provides targeted information in the sections with the following headers: Home and Community Based Service Participants and Developmental Disabilities Participants.
- Medicaid Providers and the Federal Public Health Emergency (https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/medicaidproviders-and-federal-public-health-emergency)– this page is for providers. This FAQ provides targeted information in the sections with the following headers: Developmental Disabilities Requirements, Developmental Disabilities Benefits/Limitations, and Developmental Disabilities Documentation.

b. The State published multiple Medicaid Information Release (IR) articles to assist stakeholders with unwinding PHE flexibilities as they became available. The State makes these IRs available in an Information Release library on the public website under the 2023 and 2024 IR library (https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=24604&dbid=0&repo=PUBLICDOCUMENTS). Unwinding IRs include:

- MA23-09 – COVID19 Flexibilities Under the PHE (May 10, 2023) - comprehensive summary and guidance related to unwinding of all PHE flexibilities.
- MA23-10 – Change in Provider Reimbursement Rates (May 25, 2023) – includes changes approved during the 2023 Legislative session related to the Appendix K rate flexibilities.
- MA23-20 – Administrative Rule Changes (November 6, 2023)

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

(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.:*

A. Independent Assessment Contractor (IAC).
The Department contracts with an IAC to collect participant information required to complete Level of Care (LOC) determinations and assign individualized budgets according to specific parameters as established by the single Medicaid agency as described in the contract. The IAC entity is a health and human services management company with more than ten (10) years of Centers for Medicare and Medicaid Services (CMS) certification offering assessment services statewide.

B. Program Coordination Provider.
The Department contracts with a Program Coordination Provider who provides administrative services on behalf of the Department for the oversight, quality assurance and improvement, and program coordination of the Residential Habilitation service provided by Certified Family Home (CFH) providers.

○ **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:

Contract Monitors in Medicaid's Bureau of Care Management are responsible for assessing the performance of the Independent Assessment Contractor (IAC) contract and the Residential Habilitation Program Coordination contract.

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:

A. Independent Assessment Contractor (IAC) Contract Monitoring.

1. Monthly IAC Data and Review. Contract Monitors in the Medicaid Bureau of Care Management collect data reflecting the IAC's performance according to the defined business model and timeframes. When performance measures are not met, or there are changes in performance expectations, the Contract Monitor(s), Program Managers from the Medicaid Bureau of Developmental Disabilities Services (BDDS), and the IAC discuss the issues and identify necessary changes. The Department conducts ongoing monthly reviews of data.

2. Quarterly Contract Monitoring Report. This report reviews each performance standard and provides information in relation to compliance. If the performance was not satisfactory, the Contract Monitor follows-up by developing a plan of correction specific to the problem area.

3. IAC Performance Review. The Contract Monitor(s) reviews IAC records to establish that regional IAC offices are consistent with the statewide business model. Records reviewed include the following: documents are tracked and accessible; necessary signatures are obtained; documents are processed within required timeframes; accurate documentation related to participant diagnosis is available, medical history, and medical or behavioral needs are recorded, Level of Care (LOC) eligibility correctly identified~~determined~~ according to the approved contract parameters, and that demographic information is correctly recorded.

4. Outcome-Based Review. Outcome-based reviews ensure that the components of the business model are implemented consistently across the state to ensure participants receive services that meet their needs.

The Department completes annual IAC performance reviews. The information received through these review processes validates the performance of the IAC's clinical decision making.

The Department provides review information to the IAC and develops a plan of correction for those areas not meeting the contract's required performance standards. Written corrective action plans identify how issue(s) will be resolved and include timelines for resolution. The IAC resolves the identified issue(s) according to the Department accepted written corrective action plan. Failure to resolve an identified performance issue may result in the remedies as outlined in the Special Terms and Conditions of the contract being imposed.

B. Residential Habilitation Program Coordination Contract Monitoring.

1. Initial/Annual Program Implementation Plan (PIP) Completion Timeframes. The Contractor completes Certified Family Home (CFH) orientation, CFH skill building, and submits participant PIPs to the CFH provider within contract timeframes.

The Contractor completes a monthly database review of activities related to CFH training and/or development and implementation of PIPs within timeframes. An annual report includes those participants with initial/annual plans implemented during that report year.

2. Initial/Annual PIP Performance. PIP objectives and skill building instructions completed by Contractor accurately reflect participant goals identified in the participant's plan of service. The Contractor completes a monthly review of information entered into its database related to participant PIP performance. The Contractor completes a review of participant files to identify that PIP objectives and skill building instructions accurately reflect participant goals as identified in the approved plan of service/addendum(s).

Number of participant files reviewed each quarter are based on an annual sample size identified by the Department. ~~This sample size is based on the total number of participants projected to be served by the Contractor in a given year and is calculated with a five percent (5%) margin of error and a 95% confidence level.~~

3. Program Coordinator Qualifications. The Contractor's staff meet qualifications required through the Program Coordination Contract. Program Coordinators must meet Qualified Intellectual Disabilities Professional (QIDP) qualifications and experience requirements in accordance with federal regulations, obtain a criminal history clearance, have

professional liability insurance coverage, and complete at least eight (8) hours of continuing education annually in human services or relating to their work as a QIDP.

Additionally, Program Coordinators must not be a CFH provider, nor provide services to a family member or for someone to whom they are a guardian. The Contractor reviews employee files to verify that credentials, resumes, and job qualifications meet requirements. Contractors develop a quarterly report verifying the results of employee file reviews.

4. Database. The Contractor maintains a current and accurate database with sorting capabilities. The Department reviews data submitted through reports/spreadsheets and periodic review of Contractor databases. The Contractor develops an annual report which summarizes its progress and efforts related to fulfilling contract requirements, including database capabilities.

5. ~~Participant/~~CFH Residential Habilitation Satisfaction Survey. The Contractor assesses the satisfaction of participants and CFHs related to Program Coordination Services received annually.

The ~~Participant/~~CFH Residential Habilitation Satisfaction Survey is available in both paper and electronic formats for ~~all participants receiving CFH services and~~ all CFH providers.

The Contractor develops an annual report including the number ~~of participants and~~ CFH providers who responded to the survey, summary results of overall participant, and CFH provider satisfaction with Program Coordination services received, and any corrective measures and changes to the Contractor's business processes as a result of findings identified through the survey.

6. The Contractor develops and submits a monthly Complaint Data Report to the Department. This report identifies any complaints received by the Contractor regarding Program Coordination service provision. The Department reviews the Contractor's annual Survey Summary Report and monthly Complaint Data reports. When an issue is identified, the Department requires the Contractor to submit a ~~written corrective action plan~~plan for program improvement identifying how the issues will be resolved and providing timelines for resolution. ~~The Contractor resolves the identified issues according to the Department-accepted corrective action plan.~~ If the Contractor fails to resolve the identified issues in a timely manner, the Department requires the Contractor to subcontract out all or a part of their services to resolve the identified issues.

~~7. Health and Safety Reporting. The Contractor reports concerns related to participant health and safety directly to the Department and as mandatory reporters, to authorities (as applicable). The documentation identifies the date the concern was discovered or reported to the Contractor, the date the concern was submitted to the Department and authorities (as applicable), and the nature of the concern. The Contractor develops and submits a monthly Health and Safety Data report to the Department. This report identifies concerns related to participant health and safety.~~

7. The Contractor develops and submits a Monthly Certified Family Home Provider Implementation Issues Report to the Department. This monthly report identifies any issues identified in the prior month that impact the implementation of Program Coordination services for a participant requiring Department intervention.

8. Reconciled Billing. The Contractor submits monthly invoices for services provided within the Scope of Work. The Contractor develops and submits a monthly invoice for services provided.

~~Required Level of Expectation for the above performance metrics is 100% except for Initial/Annual Program Implementation Plan Performance which is 95%.~~ The Department imposes remedies for failure to resolve any identified performance issues.

C. Duals Plan Participants.

BDDS coordinates with Medicaid Duals Plans Contract Monitor(s) to ensure compliance with all terms of the Duals contracts and terms that pertain to participants on this Waiver. The Contract Monitor(s) manages corrective action plans

for violations of Duals Plan Contract requirements.

Appendix A: Waiver Administration and Operation

8. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

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

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

Data Aggregation and Analysis:

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

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.

b. Methods for Remediation/Fixing Individual Problems

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

The Medicaid Bureau of Developmental Disabilities Services (BDDS) Quality Manager oversees Quality Assurance (QA) remediation and system improvement processes and reporting.
The Medicaid BDDS QA Team identifies and addresses any statewide resource or program issues identified in QA business processes by analyzing and reporting the results to the BDDS Quality Manager and recommends program changes or system improvement processes to the Medicaid Quality Management Oversight Committee for approval.

The Medicaid BDDS Quality Oversight Committee, (comprised of the BDDS Bureau Chief, BDDS Quality Manager, BDDS Operations Managers, State Licensing & Certifications (L&C) Staff, Medicaid Contract Monitors, and Medicaid Policy Staff) reviews all data and Annual BDDS Level of Care (LOC) Report findings, identifies remediation activities, and monitors ongoing system improvement initiatives and activities.
The Medicaid BDDS Management Team identifies and addresses any statewide resource or program issues identified in QA business processes and analyzed reports. The BDDS Management Team reports the analysis to the BDDS Bureau Chief who then recommends program changes or system improvement processes to the Medicaid Central Office Management Team (COMT) for approval.

Medicaid's COMT reviews BDDS and all other Medicaid program report analyses and recommendations, considering Division-wide resources and coordination issues and strategies when making final system-wide change decisions.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☒	Autism	18		☒
	☒	Developmental Disability	18		☒
	☒	Intellectual Disability	18		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

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:

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)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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:

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:

☐ **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	7458
Year 2	7458
Year 3	7458
Year 4	7958
Year 5	8492

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:

Entry to the waiver is offered to individuals based on the date they are determined eligible for waiver services. Entrants to the waiver must:

• Be age eighteen (18) years old or older,
• Meet Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) level of care, and
• Have income at or less than 300% of SSI Federal Benefit Rate.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ○ **§1634 State**
- ◉ **SSI Criteria State**
- ○ **209(b) State**

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

- ○ **No**
- ◉ **Yes**

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

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

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

Select one:

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

Specify percentage: [ ]

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in**

§1902(a)(10)(A)(ii)(XV) of the Act)

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

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

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

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

income:

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

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

Select one:

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The special income level for institutionalized persons**

(*select one*):

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

○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

Per IDAPA 16.03.18.400.06, the Personal Needs Allowance (PNA) equals three times (300%) the federal SSI benefit amount. Additional variances from the PNA are as follows:

● 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 (and which are distinct from impairment-related work expenses described below).

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

● Persons with a 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.

○ **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:

Per IDAPA 16.03.18.400.06, the Personal Needs Allowance (PNA) equals three times (300%) the federal SSI benefit amount. Additional variances from the PNA are as follows:

● 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 (and which are distinct from impairment-related work expenses described below).

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

● Persons with a 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.

○ **Other**

Specify:

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

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant,*

not applicable must be selected.

◉ **The state does not establish reasonable limits.**

○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate 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 (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-5-a 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 that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

1

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

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

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

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

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

Specify the entity:

- ( ) **Other**

Specify:

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

Individuals performing 1915(c) evaluations/re-evaluations must be a Qualified Intellectual Disability Professional (QIDP) who meets qualifications specified in the Code of Federal Regulations, Title 42 section 483.430.

At a minimum, a QIDP must:

a. Have at least (1) year of experience working directly with persons with intellectual disability or other developmental disabilities;

b. Is one of the following:

- A Doctor of Medicine or osteopathy,
- A registered nurse,
- An individual who holds at least a bachelor's degree in a human services field (including, but not limited to sociology, special education, rehabilitation counseling, and psychology); and

c. Have training and experience in completing and interpreting assessments.

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.

Participants must meet Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Level of Care (LOC) as defined in IDAPA 16.03.10.584. ICF/IID LOC criteria for this waiver are described below.

1. Diagnosis. Must have a primary diagnosis of intellectual disability or a related condition as defined in Section 66-402, Idaho Code and Sections 500 through 505 of 16.03.10.
2. Active Treatment. Require ~~and receive~~ intensive inpatient Active Treatment as defined in IDAPA 16.03.10.010, to advance or maintain functional level.
3. Meet one (1) or more of the following criteria:
a. Functional Limitations. Qualify for ICF/IID level of care based on functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on a full-scale functional assessment using the Woodcock Johnson Scales of Independent Behavior (SIB-R) or subsequent revisions) qualify.
b. Maladaptive Behavior. Persons may qualify for ICF/IID LOC based on the following maladaptive behavior scores:
• Minus Twenty-two (22) or Below Score on the General Maladaptive Index on the Woodcock Johnson Scales of Independent Behavior (SIB-R) or subsequent revision is minus twenty-two (-22) or less; or
• Above a minus Twenty-two (22) Score. Persons engaging in aggressive or self-injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and requires Active Treatment to control or decrease the behavior qualify.
c. Combination Functional and Maladaptive Behaviors. Persons displaying a combination of criteria at a significant level that can been determined to need of the level of services provided in an ICF/IID, including Active Treatment services. Significant Levels include having an overall age equivalency of up to eight and one-half (8 1/2) years is significant in the area of functionality when combined with a General Maladaptive Index on the Woodcock Johnson SIB-R up to minus seventeen (-17), minus twenty-two (-22) inclusive.
d. Medical Condition. Individuals with a medical condition that significantly affects their functional level/capabilities and requires the level of services provided in an ICF/IID, including Active Treatment qualify.

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:

1. Initial Level of Care (LOC) Evaluation Process.
Individuals applying for 1915(c) waiver services must submit an initial Eligibility Application for Adults with Developmental Disabilities to the Bureau of Developmental Disability Services (BDDS) in the region in which the participant seeking services resides. Applications are completed in paper format and may be submitted to BDDS by hand delivery, U.S. mail, fax, or email.

Within three (3) days of receiving the application for services, BDDS verifies the participant's financial eligibility for Medicaid, then forwards the application to the Department's Independent Assessment Contractor (IAC), to begin collecting information required to determine if the participant meets Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) LOC criteria.

The state completes the initial ICF/IID LOC eligibility determination process within thirty (30) days of receiving a complete application. This process includes the following:

a. The IAC requests a current Health and Physical Report/Medical Care form (completed within the prior six (6) months) from the participant's Primary Care Physician.
b. The IAC contacts the participant or their decision-making authority (if applicable) to identify who will serve as a respondent for the assessments. The participant or their decision-making authority (if applicable) must be involved throughout the process. The individual/their decision-making authority is responsible for identifying a respondent who has knowledge about the participant's current level of functioning. The participant is required to be present with the respondent for a face-to-face meeting with the Department to complete the initial eligibility assessment process.
c. During the face-to-face meeting, the participant (or respondent for the participant) completes the Scales of Independent Behavior Revised (SIB-R) assessment and Medical, Social, Developmental Assessment Summary using an instrument approved by the Department. These ~~uses these~~ assessments, in addition to other required documentation, are used to verify ICF/IID LOC criteria as follows:
i. Developmental Disability Diagnosis. The IAC obtains evaluations and other medical records or information needed to verify the primary diagnosis of Developmental Disability. Developmental
Disability means a chronic disability which appears before the age of twenty-two (22) years and is attributable to an impairment such as Developmental Disability, Cerebral Palsy,
epilepsy, autism, or another condition closely related to or like one of these impairments and that requires treatment or services. Participants must provide the IAC with the
results of psychometric testing if eligibility for Developmental Disabilities Services is based on a Developmental Disability, and they have no prior testing or prior testing is
inconclusive. Documentation of diagnosis is required for participants whose eligibility is based on a Developmental Disability other than an Intellectual Disability.
ii. Functional, Maladaptive or Medical Limitations. The IAC administers a SIB-R to verify the participant's Developmental Disability results in substantial functional impairment in
three (3) or more of seven (7) areas of major life activity and meets ICF/IID LOC criteria based on level of functioning, maladaptive behavior, or a combination of functioning and
maladaptive behavior. (IDAPA 16.03.10.584.05-07). For individuals who meet ICF/IID LOC based on medical criteria (IDAPA 16.03.10.584.08). ~~the IAC coordinates with a Nurse Reviewer~~
~~within the Department's Bureau of Long-term Care (BLTC) to complete a Supplemental Medical Assessment for ICF/IID LOC Determination, in addition to completing the SIB-R. The~~
~~Supplemental Medical Assessment is completed to determine whether a medical condition has or will significantly affect the functional level or capabilities of a Developmentally~~
~~Disabled individual who otherwise may not meet ICF/IID LOC. The IAC must maintain supportive documentation with the Supplemental Medicaid Assessment. A medical condition, for the~~
~~purposes of the Supplemental Medicaid Assessment, refers to any chronic or recurrent medical condition, requiring continued medical treatment or follow-up and significantly impacts~~
~~the individual's functioning.~~
iii. Must Require Certain LOC. The IAC completes a Medical, Social, Developmental Assessment Summary to validate the participant requires the LOC provided in an ICF/IID, including
Active Treatment, and in the absence of available intensive alternative services in the community, would require institutionalization.
d. At the time of the face-to-face meeting, an Inventory of Individual Needs is completed with the participant/respondent. This assessment is used to calculate an annual budget according to the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to the persons disability.

e. Participants receive notification of the initial decision prior to Care Managers in BDDS reviewing the Support Plan and signing the authorization for services.
f. BDDS Care Managers review determinations for participants and request updates or corrections when information collected by the IAC falls outside of contract parameters. Similarly, when participants do not agree with an eligibility determination or calculated budget amount, they can request a Fair Hearing. All Fair Hearing requests are reviewed by the BDDS Appeals Team including preliminary LOC determinations for accuracy and requests updates from the IAC as needed.
g. The state maintains all documentation associated with the initial eligibility assessment in the member's electronic case file in the database.

2. Annual LOC Evaluation/Revaluation Process.
Except for the following differences, the annual eligibility re-determination process is the same:

Participants are not required to submit a new Eligibility Application for Adults with Developmental Disabilities Application on an annual basis.

When a change in the participant's income results in loss of Medicaid financial eligibility, the participant may appeal the Department's decision. To assure the health and safety of the participant, the Department extends eligibility and the existing plan of service during the Administrative Appeals process. Claims submitted for reimbursement by providers continue to be paid until all Administrative Appeal rights are exhausted. If the determination is upheld on Administrative Appeal, provider claims will not be paid after the date of the final decision. Medicaid providers are required to verify participant eligibility prior to providing services as approved on the annual Individual Service Plan (ISP).

Participants must receive a new assessment at least every three (3) years when the existing SIB-R does not accurately describe the current status of the participant as determined by a review of participant documentation and information provided during the annual face-to-face eligibility re-determination meeting. However, if a participant's SIB-R scores in the prior year were borderline, the participant must complete a new SIB-R as part of the annual eligibility redetermination process. Borderline scores include:
a. When the person met ICF/IID LOC based on functional criteria, a new SIB-R is completed if the participants age equivalency is between ages of six (6) years and six~~five~~ (65) months and eight (8) years, OR
b. When the person met ICF/IID LOC eligibility based on Maladaptive Behavior Criteria, a new SIB-R is completed if the participants General Maladaptive Index score falls between -22 and -25, OR
c. When the person met eligibility based on a combination of age equivalency and maladaptive score, a new SIB-R is completed annually.

Those sections of the Medical, Social, Developmental Assessment Summary are updated when the respondent indicates a change in status.

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):*

The Department uses an electronic database to track annual redetermination dates and ensures timely reevaluations. The Department ensures compliance with timely reevaluations through monitoring of quarterly reports and annual statewide reviews.

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:

The Independent Assessment Contractor (IAC) maintains all participant records for five (5) years after the participant's most recent assessment.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver applicants for whom an ICF/IID level of care evaluation was completed prior to receiving waiver services. a. Numerator: Number of waiver applicants for whom an ICF/IID level of care evaluation was completed prior to receiving waiver services. b. Denominator: Number of waiver applicants.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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 & percent of Level of Care (LOC) determinations made with appropriately applied processes/instruments and according to approved description for determining LOC. a. Numerator: Number of LOC determinations made with appropriately applied processes/instruments and according to approved description for determining LOC. b. Denominator: Number of LOC determinations in representative sample.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with +/- 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

The Medicaid's Bureau of Care Management monitors the Independent Assessment Contractor (IAC) to ensure Level of Care determinations are completed according to approved criteria in the contract. Idaho evaluates the IAC's performance through a variety of Quality Assurance (QA) and Contract Monitoring processes. These processes include immediate communication of issues identified.

Idaho's contract requires submission of monthly, quarterly, semi-annual, and annual reports. The Contract Monitor reviews and analyzes the data presented to ensure the contractor has met the requirements for timeliness of the report, the formatting and presentation of the data match the contract parameters, and any applicable performance metrics are met. The IAC records the results of the review in the appropriate location. If any deficiency is identified the Contract Monitor notifies the IAC of the deficiencies and the actions required to remediate the issue via the appropriate Contract Monitoring Report. If the IAC fails to remediate the issue, the Contract Monitor addresses those areas with the IAC via the Corrective Action process outlined in the Standard Terms and Conditions and Contract Scope of Work.

Idaho's Contract also requires the Contract Monitor and IAC to meet weekly to discuss successes, and challenges, program improvement, and program updates. If there are any items that have been identified as immediate needs those are discussed, and a plan developed for remediation with the IAC. For any action items previously communicated to the IAC on a Monitoring Report, the IAC provides updates. The updates are recorded on the appropriate monitoring tools.

Idaho's Contract Monitor performs a quarterly QA review of Assessments. The Contract Monitor receives a report of all assessments completed during that quarter and randomly selects a sample to review. The review includes, but is not limited to, eligibility timelines, incomplete or missing progress notes, plan types, and participant demographics. The percentage of errors is reported to CMS on the required quarterly reporting. If any errors are identified the Contract Monitor records this in the Contract Monitoring document and reports sent to the IAC. For errors requiring immediate resolution, the Contract Monitor reaches out to the IAC to request a resolution.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The Bureau of Developmental Disability Services (BDDS) sends individuals inquiring about adult Developmental Disabilities (DD) services an application packet. Each application packet includes a hand-out that identifies all adult DD services available. This handout specifies which services are available to persons who are determined eligible and which services are available to persons who meet Level of Care (LOC) for placement in an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Eligibility Application for Adults with Developmental Disabilities included in the application packet also allows a person to choose which services they are seeking from a list. This list includes DD Waiver Services (traditional or self-directed community supports), State Plan Home and Community Based Services, or Other. In addition, information on all adult DD services is included on the public Health and Welfare website (https://healthandwelfare.idaho.gov/ services-programs/medicaid-health/apply-adult-developmental-disabilities-programs).

In addition, participants choosing to access traditional DD and/or waiver services in lieu of placement in an ICF/IID develop an Individual Service Plan (ISP) that identifies the services they wish to receive. The signature page of the ISP includes a statement for the participant and their legal guardian (as applicable) to initial indicating they understand the participant has a choice between DD services and placement in an ICF/IID. This statement reads as follows: "I have been informed of and understand my choice of DD waiver services. I choose to receive waiver services rather than to accept placement in an Intermediate Care Facility for Intellectually Disabled (ICF/IID). I understand that I may, at any time, choose facility admission." An ISP is not reviewed and approved unless the participant/guardian has initialed this statement.

Participants choosing to access consumer-directed community supports under the DD Waiver in lieu of placement in an ICF/IID must develop a Support and Spending Plan (SSP) that identifies the type of consumer-directed supports they wish to receive. The SSP includes a page titled "Choice and Informed Consent Statements" for the participant and their legal guardian (as applicable) to sign to indicate they understand the participant has a choice between consumer-directed services and placement in an ICF/IID. This statement reads as follows: "I have been informed of and understand my choice of DD waiver services. I choose to receive DD waiver services rather than to accept placement in an Intermediate Care Facility for Intellectually Disabled (ICF/IID). I understand that I may, at any time, choose facility admission." An SSP~~ISP~~ is not reviewed and approved unless the participant/guardian has signed this statement.

For participants accessing traditional services, the Service Coordinator answers questions or assists individuals with information about alternatives and services. Support Brokers assist participants with information about alternatives and services for participants accessing consumer-directed services. BDDS Care Managers also assist participants with questions related to alternatives and services.

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.

The Department's Independent Assessment Contractor (IAC) maintains electronically retrievable copies of Individual Service Plans (ISP) and Support and Spending Plans (SSP) indicating the participant's freedom of choice for a minimum of three (3) years in a department-owned database.
Additionally, providers responsible for developing the ISP/SSP retain a copy. The requirement for record retention and the length of time these records must be retained is specified in the following rules:

• IDAPA 16.03.10.040.05. Providers must retain participant records for five (5) years from the date the final payment was made under the Provider Agreement. Failure to retain records for the required period voids the Department's obligation to make payment for the goods or services.

• IDAPA 16.03.10.704.04. Providers must retain their participant's records for five (5) years following the date of service. The Department maintains Closed Case records for all participants after waiver services close.

Also, for participants accessing traditional waiver services, IDAPA 16.03.10.728.03. m. requires the Plan Developer/Service Coordination agency to maintain records documenting the participant was informed of the purposes of Service Coordination, their rights to refuse Service Coordination, and the right to choose their Service Coordinator and other service providers'. Per IDAPA 16.03.10.040.05 and 16.03.10.704.04, informed consent documentation must be maintained for a minimum of five (5) 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 Department's ensures persons with limited English skills can effectively access Medicaid services. More specifically, the Department provides effective communications for anyone who has Limited English Proficiency (LEP), or is deaf/hard of hearing or blind, and ensures interpreter services are provided on an as needed basis at no cost to them.

The state's Directory of Interpreter/Communication Resources lists sources available to help staff obtain the type of assistance needed when communicating with someone limited in communication ability. The External Resources Section of the Directory helps 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 also assists with 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 ask their immediate supervisor. If staff require further assistance, they may contact the Department's Civil Rights Manager.
Interpreter sources include:

1. Foreign Languages.
a. Department of Health and Welfare employees with identified 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 skill.
b. Over-the-Phone Interpretation Services provide over-the-phone interpretation twenty-four (24) hours a day, seven (7) days a week. This service is used with discretion and limited to short conversations generally associated with the gathering and dissemination of initial information and possibly the resolution of immediate problems. Telephone conversations are done in a private location (such as an office or interview room) and should be conducted with the use of a speakerphone, if possible.
c. On-Call Individual and/or Contract Interpreters are used when employees listed as internal interpreters in the Department's Directory of Interpreter/Communication Resources are not available. Staff work with their supervisor to contact one of the On-Call Individual and/or Contract Interpreters in their area.
d. Other. If appropriate interpreters cannot be identified by using the sources listed in this procedure, staff contact their Human Resource Specialist or the Department's Civil Rights Manager at (208) 334-5617, for further assistance.

2. 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.

3. Sign Language provided by Network Interpreting Service (NIS) schedules interpreters for a fee (1-800-284-1043). To identify the local sign language interpreting services available in the area, staff refer to Regional Off-Site Resources in the Department's Directory of Interpreter/Communication Resources.

4. The Department of Health and Welfare's Web page (http://www.healthandwelfare.idaho.gov/) includes a drop-down at the top of the website for individuals to select from a list of languages when viewing the website.

5. The 2-1-1 Idaho Care Line offers toll-free statewide services with translation assistance available to link Idahoans to health or human service providers and programs.

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	**Residential Habilitation**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Supports for Participant Direction	**Financial Management Services**		
Supports for Participant Direction	**Support Broker Services**		
Other Service	**Adult Day Health**		
Other Service	**Behavior Consultation/Crisis Management**		
Other Service	**Chore Services**		
Other Service	**Community Support Services (Participant Direction)**		

Service Type	Service
Other Service	Environmental Accessibility Adaptations
Other Service	Home Delivered Meals
Other Service	Non-Medical Transportation
Other Service	Personal Emergency Response System
Other Service	Skilled Nursing
Other Service	Specialized Medical Equipment and Supplies
Other Service	Transition Services

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Residential Habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible participants and designed to assist with residing successfully in their own homes, with their families, or in a Certified Family Home (CFH). The services and supports options include the following:
a. Habilitation Services to assist the individual with acquiring, retaining, or improving their ability to reside as independently as possible in the community or maintaining family unity. Habilitation Services include training in one (1) or more of the following areas:
i. Self-direction, including the identification of and response 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 including training or assistance with handling personal finances, making purchases, and meeting personal financial obligations;
iii. Daily living skills including 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, home safety, first aid, and emergency procedures;
iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the
participant to their community. (Socialization training associated with participation in community activities includes helping identify activities of interest, working out arrangements to
participate in such activities, and identifying specific training activities necessary to ensure continued participation in such activities. Socialization training does not include
participation in non-therapeutic activities, which are merely diversional or recreational in nature);
v. Mobility includes 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; and
vi. Behavior-shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or
extension of therapeutic services, which consist of reinforcing physical, occupational, speech, and other therapeutic programs.
b. Personal Assistance Services necessary to assist the individual with daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on their own behalf.
c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce Habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self-direction, money management, socialization, mobility, and other therapeutic programs.

Provider owned or leased facilities where residential services are furnished must be compliant with the Americans with Disabilities Act.
Participants authorized to receive Intense Supported Living services or High Supported Living Services will not be authorized to receive Developmental Therapy services, Adult Day Health services, or Non-Medical Transportation services because these services are included in the Intense Support daily rate and High Supports daily rate.

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	Certified Family Home Provider
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:

Individual

Provider Type:

Certified Family Home Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified Family Home (CFH) certificate as described in IDAPA 16.03.19, “Certified Family Homes”.

Other Standard *(specify):*

1. An individual who provides direct Residential Habilitation services in their own home must be certified by the Department to operate a Certified Family Home (CFH) under IDAPA 16.03.19," Certified Family Homes", and must receive Residential Habilitation Program Coordination Services provided through the Department, or its contractor, for the Residential Habilitation services provided.

2. CFH providers providing Residential Habilitation services on this waiver must meet the following minimum qualifications:
a. Be at least eighteen (18) years of age;
b. Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service;
c. Have current CPR and First Aid certifications;
d. Be free from communicable diseases;
e. If transporting participants, have a current and valid driver's license and vehicle insurance;
f. Each CFH provider of Residential Habilitation services 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.
g. CFH providers of Residential Habilitation services who provide direct care and services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06,
"Criminal History and Background Checks"; and
h. Have appropriate certification or licensure required to perform tasks which require certification or licensure.

3. All skill training for CFH providers providing Residential Habilitation services must be provided through the Department or its contractor by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs.

4. Prior to delivering Residential Habilitation services to a participant, the CFH provider must complete an orientation training in the following areas as provided by either the Department, its contractor, or both, and include the following areas:
a. Purpose and philosophy of services;
b. Service rules;
c. Policies and procedures;
d. Proper conduct in relating to waiver participants;
e. Handling of confidential and emergency situations that involve the waiver participant;
f. Participant rights;
g. Methods of supervising participants; and
h. Training specific to the needs of the participant.

5. Additional training requirements for CFH providers providing Residential Habilitation services must be completed by the CFH provider within six (6) months of certification date and include a minimum of the following:
a. Instructional Techniques: Methodologies for training in a systematic and effective manner;
b. Managing behaviors: techniques and strategies for teaching adaptive behaviors;
c. Feeding;
d. Communication;
e. Mobility;
f. Activities of daily living;
g. Body mechanics and lifting techniques;
h. Housekeeping techniques; and
i. Maintenance of a clean, safe, and healthy environment.

6. The Department or its contractor is responsible for providing on-going training to the CFH provider of Residential Habilitation specific to the needs of the participant as needed.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

Certification for Certified Family Homes (CFH) is required the year after the initial home certification study and at least every twenty-four (24) months thereafter.

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 16.04.17, “Residential Habilitation Agencies.”

Other Standard *(specify):*

When Residential Habilitation services are provided by an agency, the agency must meet the requirements of a Residential Habilitation Agency under IDAPA 16.03.10.705.01 and must be capable of supervising the direct services provided. Individuals providing 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:

1. Direct service staff must meet the following minimum qualifications:
a. Be at least eighteen (18) years of age;
b. Be a high school graduate or have a GED or demonstrate the ability to provide services according to a plan of service;
c. Have current CPR and First Aid certifications;
d. Be free from communicable diseases;
e. If transporting participants, have a current and valid driver's license and vehicle insurance;
f. 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;
g. Residential Habilitation service providers providing direct care services must satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; and
h. Have appropriate certification or licensure required to perform tasks which require certification or licensure.

2. All skill training for agency direct service staff must be provided by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs.

3. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects:
a. Purpose and philosophy of services;
b. Service rules;
c. Policies and procedures;
d. Proper conduct in relating to waiver participants;
e. Handling of confidential and emergency situations that involve the waiver participant;
f. Participant rights;
g. Methods of supervising participants;
h. Working with individuals with developmental disabilities; and
i. Training specific to the needs of the participant.

4. Additional training requirements must be completed within six (6) months of employment with the Residential Habilitation Agency and include at a minimum:
a. Instructional techniques: Methodologies for training in a systematic and effective manner;
b. Managing behaviors: Techniques and strategies for teaching adaptive behaviors;
c. Feeding;
d. Communication;
e. Mobility;
f. Activities of daily living;
g. Body mechanics and lifting techniques;
h. Housekeeping techniques; and
i. Maintenance of a clean, safe, and healthy environment.

5. The provider agency is 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 and Welfare

Frequency of Verification:

Residential Habilitation providers are surveyed when seeking renewal of their certificate. The Department issues certificates that remain in effect for a period of no longer than three (3) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Respite Care. Short-term breaks from caregiving responsibilities to non-paid caregivers. The caregiver or participant selects, trains, and directs the provider. While receiving Respite Care services, the 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, the private home of the Respite Care provider, the community, a Developmental Disabilities Agency (DDA) or an Adult Day Health Facility.

Respite Care may be provided for a few hours for up to several days, not to exceed thirty (30) consecutive days.

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 Provider
Agency	Respite Care Provider

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 Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of Respite Care services must meet the following minimum qualifications:
a. Received caregiving instructions for the needs of the person receiving the service;
b. Demonstrate the ability to provide services according to a plan of service;
c. Be free of communicable diseases; and
d. Respite Care service providers of 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

Frequency of Verification:

At least every two (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:

Respite Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of Respite Care services must meet the following minimum qualifications:
a. Received caregiving instructions for needs of the person receiving the service;
b. Demonstrate the ability to provide services according to a plan of service;
c. Be free of communicable diseases; and
d. Respite Care service providers of 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:

The Department of Health and Welfare

Frequency of Verification:

At least every two (2) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

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. Due to the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform their work.

a. Supported Employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or the IDEA.
b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employers' participation in a Supported Employment program; payments that are passed through to beneficiaries of Supported Employment programs; or payments for vocational training that are not directly related to a participant's Supported Employment program.
Supported Employment includes activities needed to sustain paid work at or above the minimum wage by participants, including oversight and training. Service payment is made only for the adaptations, oversight, and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.
c. Supported Employment services do not include employment services offered under other waiver services or State programs. Idaho's Division of Vocational Rehabilitation may assist participants with locating a job or developing a job on behalf of the participant.
d. Transportation of the participant to and from the job site is not covered under this Supported Employment service but may be provided as Non-Medical Transportation (a separate billable service).

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

The combination of Developmental Therapy, Adult Day Health, and Supported Employment must not exceed forty (40) hours per 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	Supported Employment Agencies

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 Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF); or other comparable standards; or meet State requirements to be a State approved provider. Supported Employment service providers of 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."

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

At least every two (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:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Financial Management Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The Department offers Financial Management Services through any qualified Fiscal Employer Agent (FEA).

FEA providers complete financial consultation and services for participants choosing to self-direct their services. This assures that the financial and budgeting information is accurate and available to them as is necessary for successful self-direction to occur. Services include:
a. Providing payroll and accounting supports to participants choosing the self-directed community supports option.
b. Performing financial reporting for employees of each participant.
c. Preparing and distributing the Financial Information Packet that includes Department-approved agreement forms for participants hiring their own staff.
d. Processing and paying timesheets and invoices for Community Support Workers and Support Brokers, as authorized by the participant, according to the participant's Department-authorized Support and Spending Plan (SSP).
e Managing and processing payments of required state and federal employment taxes for the participant's Community Support Worker and Support Broker.
f. Processing and paying invoices for goods and services, as authorized, according to the participant's SSP.
g. Providing each participant with information and data to assist the participant with managing and spending their individual budget.
h. Participating in the Department’s Quality Assurance (QA) and Improvement activities.

FEAs complete Financial Services and Financial Consultation for participants and/or their representatives that relates to their self-directed individual budget. FEAs assure that financial data related to the participant's budget is accurate and available to them or their representative as necessary to ensure successful self-direction. FEA qualifications, requirements, responsibilities, and allowable activities are described in IDAPA 16.03.13 - “Consumer-Directed Services”.

Only participants who select the self-directed option may access this service.

FEAs must not provide any other direct services (including Support Broker services) to participants ensuring no conflict of interest exists; nor employ the guardian, parent, spouse, payee, or conservator of the participant, or use direct control over the participant's choice of these providers.

FEAs may only provide financial consultation, financial information and financial data to participants or their representatives and may not provide counseling or information about other goods and services.

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	Fiscal Employer/Agent

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Fiscal Employer/Agent

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Fiscal Employer Agents (FEA) must meet the requirements outlined in the Provider Agreement with the Department, and Section 3504 of the Internal Revenue Code. Requirements of the FEA include:
• Obtaining Federal Employer Identification Numbers (FEIN) to file tax forms and make tax payments on behalf of a participant,
• Reporting irregular activities or practices that conflict with federal or state rules and regulations,
• Maintaining a policy and procedures manual,
• Providing a website with Secure File Transfer Protocol (SFTP) for the Department to access. The site must have the capability of allowing participants and their employees to access individual specific information such as timecards and account statements,
• Preparing, submitting, or revoking IRS forms in accordance with IRS requirements,
• Obtaining an Idaho State Tax Commission Power of Attorney (Form ID-POA) from each participant it represents,
• Revoking the Idaho State Tax Commission Power of Attorney (Form ID-POA when the provider no longer represents the participant,
• Providing a customer service system to respond to all inquiries from participants, employees, agencies, and vendors,
• Receiving, responding to, and tracking all complaints from any source,
• Implementing and enforcing policies and procedures regarding documents that are mailed, faxed, or emailed to and from the provider ensuring documents are tracked, that confidential information is not compromised, is stored appropriately and not lost, and is traceable for historical research purposes,
• Submitting participant enrollment and employee packets to the Department for approval,
• Distributing Department-approved participant enrollment packets and employment packets to the participant within two (2) business days after the participant requests the packets,
• Processing payroll, including timesheets and tax withholdings, in accordance with the participant's support and spending plan (SSP),
• Tracking and logging time sheet billing errors or time sheets that cannot be paid due to late arrival or missing and/or erroneous information. The provider must notify the employee and participant within one (1) business day of when errors are identified on the timesheets,
• Tracking and logging occurrences of improperly cashed or improperly issued checks and stopping payment on checks when necessary,
• Verifying employee documentation and processing employee payments via check, direct deposit, or pay cards as per preference of employees,
• Processing vendor payments,
• Processing independent contractor or outside agency payments,
• Completing end-of-year processing,
• Transitioning a participant to a new FEA when requested,
• Conducting an annual participant satisfaction survey,
• Providing a Quality Assurance (QA) process, and
• Maintaining a Disaster Recovery Plan for electronic and hard copy files that includes restoring software and data files, and hardware backup if management information systems are disabled or servers are inoperative.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Welfare

Frequency of Verification:

At the time of application, as indicated by a readiness review to be conducted by the Department for all Fiscal Employer Agent (FEA) providers and thereafter at least every two (2) years by Department review.

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:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Support Broker Services

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Support Brokers provide counseling and assistance for participants with arranging, directing, and managing goods and services. They serve as the agent or representative of the participant to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. This includes providing participants with any assistance they need for gathering and reviewing their budget and financial data and reports prepared and issued to them by the Fiscal Employer Agency (FEA). Support Brokers offer practical skills training to enable participants to remain independent. Examples of skills training include helping participants understand the responsibilities involved with directing services, providing information on recruiting and hiring Community Support Workers, managing workers, and providing information on effective communication and problem-solving. The extent of Support Broker Services furnished to the participant must be specified on the Support and Spending Plan (SSP).

Support Broker Services may include only a few required tasks or be provided as a comprehensive service package depending on the participant's needs and preferences. At a minimum, the Support Broker must:
a. Participate in the person-centered planning process;
b. Develop a written SSP with the participant that includes the supports the participant needs and wants, related risks identified with the participant's wants and preference, and a comprehensive risk plan for each potential risk including at least three (3) back-up plans should a support fail;
c. Assist the participant with monitoring and reviewing their budget through data and financial information provided by the FEA;
d. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department;
e. Participate with Department Quality Assurance measures, as requested; and
f. Assist the participant with scheduling assessments required to complete the Department's annual determination process as needed, including assisting the participant or their representative with updating the SSP and submitting it to the Department for authorization;.
g. Assist the participant, as needed, to meet the participant responsibilities and assist the participant, as needed, to protect their own health and safety;
~~g.~~h. Complete the Department-approved criminal history check waiver form when a participant chooses to waive the criminal history check requirement for a community support worker.

In addition to the required minimum Support Broker duties, the Support Broker must be able to provide the following services when requested by the participant:
a. Assist the participant with developing and maintaining a circle of support;
b. Help the participant learn and implement the skills needed to recruit, hire, and monitor Community Supports;
c. Assist the participant with negotiating rates for paid Community Support Workers;
d. Maintain documentation of supports provided by each Community Support Worker and the participant's satisfaction with these supports;
e. Assist the participant with monitoring Community Supports;
f. Assist the participant with resolving employment-related problems;
g. Assist the participant with identifying and developing community resources to meet specific needs;
~~g.~~h. Assist the participant in distributing the support and spending plan to community support workers or vendors.~~.~~

Support Broker qualifications, requirements, and responsibilities as well as allowable activities are described in IDAPA 16.03.13 – "Consumer-Directed Services."

Only participants who select the Self-Directed option may access this service.

Support Brokers may not act as FEAs, instead Support Brokers work together with the participant to review financial information produced and maintained by the FEA.

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	Support Broker

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Support Broker Services

Provider Category:

Individual

Provider Type:

Support Broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A Support Broker providing services to a participant accessing Consumer-Directed Services must meet the following qualifications:
• Be eighteen (18) years of age or older,
• Have skills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field,
• Have at least two (2) years verifiable experience with the target population and knowledge of services and resources in the Developmental Disabilities field,
• Successfully pass an application exam,
• Complete a criminal history check, including clearance in accordance with IDAPA 16.05.06, “Criminal History and Background Checks,” and
• Complete an Employment Agreement with the participant identifying the specific tasks and services required of the Support Broker.

Support Brokers must not be the guardian, parent, spouse, payee or conservator of the participant.

All Support Brokers must document a minimum of twelve (12) hours per year of ongoing, relevant training related to Support Broker Services.

The Support Broker must not provide or be employed by an agency that provides paid Community Supports to the same participant; and must meet the conflict-of-interest standards described in IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits,” Section 721.03.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Welfare, and
The Participant

Frequency of Verification:

At the time of application, annual review of ongoing education requirements, and by participant when entering into Employment Agreement.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Day Health

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04060 adult day services (social model)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

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 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.

Transportation between participant's place of residence and Adult Day Health service site is not included in the Adult Day Health rate but may be provided as Non-Medical Transportation (a separately billable service).

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

Adult Day Health cannot exceed (30) hours per week either alone or in combination with Developmental Therapy.

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
Individual	Adult Day Health

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Health

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Certified Family Homes".

Other Standard *(specify):*

Adult Day Health services must be delivered through an executed provider agreement with the provider and Medicaid. Providers are reviewed during the initial provider agreement approval and through the renewal process. After the initial provider agreement is approved, providers are reviewed at least every three (3) years, and as needed based on service monitoring concerns.

Providers of Adult Day Health must meet the following:
a. Services provided in a facility must meet the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)";
b. Adult Day Health providers of direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks";
c. Providers of Adult Day Health services must notify the Department on behalf of the participant, when Adult Day Health is provided in a Certified Family Home (CFH) other than the participant's primary residence. The Adult Day Health provider must be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's Residential Habilitation plan; and
d. Be free from communicable disease.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

At least every three ~~two~~ (32) years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Day Health

Provider Category:

Individual

Provider Type:

Adult Day Health

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, “Certified Family Homes”.

Other Standard *(specify):*

Adult Day Health services must be delivered through an executed provider agreement with the provider and Medicaid. Providers are reviewed during the initial provider agreement approval and through the renewal process. After the initial provider agreement is approved, providers are reviewed at least every three (3) years, and as needed based on service monitoring concerns.

Providers of Adult Day Health must meet the following:
a. Services provided in a facility must meet the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)";
b. 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";
c. Providers of Adult Day Health services must notify the Department on behalf of the participant, if Adult Day Health is provided in a certified family home other than the participant's primary residence. The Adult Day Health provider must be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan; and
d. Be free from communicable disease.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

At least every three~~two~~ (3~~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:

Behavior Consultation/Crisis Management

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 3:	**Sub-Category 3:**

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Behavior Consultation/Crisis Management service provides direct consultation and clinical evaluation of individuals currently experiencing or expected to experience, a psychological, behavioral, or emotional crisis. This service may also be used to provide training and staff development related to the needs of a recipient. These services include the provision of emergency back-up involving the direct support of the individual in crisis by assisting direct care staff with intervention and stabilizing the individual in accordance with the approved Service Plan.

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	Behavior Consultation/ Crisis Management
Individual	Behavior Consultation/ Crisis Management

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Consultation/Crisis Management

Provider Category:

Agency

Provider Type:

Behavior Consultation/ Crisis Management

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Behavior Consultation/Crisis Management providers must meet the following:
a. Work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and
b. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education, or a closely related course of study; or
c. Be a licensed pharmacist; or
d. Be a Qualified Intellectual Disabilities Professional (QIDP).
e. Emergency back-up providers must meet the minimum Residential Habilitation provider qualifications described under IDAPA 16.04.17, “Residential Habilitation Agencies.”
f. Behavior Consultation/Crisis Management providers of 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.”

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health and Welfare

Frequency of Verification:

At least every two (2) years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Consultation/Crisis Management

Provider Category:

Individual

Provider Type:

Behavior Consultation/ Crisis Management

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Behavior Consultation/Crisis Management providers must meet the following:
a. Work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and
b. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or
c. Be a licensed pharmacist; or
d. Be a Qualified Intellectual Disabilities Professional (QIDP).
e. Emergency back-up providers must meet the minimum Residential Habilitation provider qualifications described under IDAPA 16.04.17, "Residential Habilitation Agencies."
f. Behavior Consultation/Crisis Management providers of 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."

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

At least every two (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:

Chore Services

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

1. Intermittent assistance includes:
a. Yard maintenance,
b. Minor home repair,
c. Heavy housework,
d. Sidewalk maintenance, and
e. Trash removal to assist the participant to remain in their home.

2. Chore activities may include the following:
a. Washing windows,
b. Moving heavy furniture,
c. Shoveling snow to provide safe access inside and outside the home,
d. Chopping wood when wood is the participant's primary source of heat, and
e. Tacking down loose rugs and flooring.

3. These services are only available when neither the participant, nor anyone else in the household can perform or financially provide services for them, and where no other relative, caretaker, landlord, community volunteer, agency, or third-party payer is willing to, or is responsible for these services.

4. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is 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	Chore Services
Individual	Chore Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Chore Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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 providing 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

Frequency of Verification:

At least every two (2) years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Individual

Provider Type:

Chore Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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 providing 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

Frequency of Verification:

At least every two (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:

Community Support Services (Participant Direction)

HCBS Taxonomy:

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Community Support Services provide medically necessary goods and supports that minimize the participant's need for institutionalization and address the participant's preferences for:
- Job support to help the participant secure and maintain employment or attain job advancement;
- Personal support to help the participant maintain health, safety, and basic quality of life;
- Relationship support to help the participant establish and maintain positive relationships with immediate family members, friends, spouse, or others in order to build a natural support network and community;
- Emotional support to help the participant learn and practice behaviors consistent with their goals and wishes while minimizing interfering behaviors; and
- Learning support to help the participant learn new skills or improve existing skills that relate to their identified goals.

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

Only participants who select the Self-Directed option may access this service. ~~There are no limits on the amount, frequency, or duration of these services other than the participant must stay within their prospective individual budget amount.~~ The participant must stay within their prospective individual budget amount and services must be cost effective when comparing to comparing reasonable alternatives.

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	Community Support
Individual	Community Support

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Support Services (Participant Direction)

Provider Category:
Agency

Provider Type:

Community Support

Provider Qualifications

License *(specify):*

When required to provide identified goods or supports.

Certificate *(specify):*

When required to provide identified goods or supports. For example, when the Community Support Worker provides services in their home, the home must be a Certified Family Home.

Other Standard *(specify):*

Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and a statement of qualification to provide identified supports.

Verification of Provider Qualifications

Entity Responsible for Verification:

- The Participant
- The Participant's Support Broker, and
- The Department of Health and Welfare (during retrospective quality assurance reviews).

Frequency of Verification:

Initial and annually, during review of employment/vendor agreements.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Support Services (Participant Direction)

Provider Category:

Individual

Provider Type:

Community Support

Provider Qualifications

License *(specify):*

When required to provide identified goods or supports.

Certificate *(specify):*

When required to provide identified goods or supports. For example, when the Community Support Worker provides services in their home, the home must be a Certified Family Home.

Other Standard *(specify):*

Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and a statement of qualification to provide identified supports.

Verification of Provider Qualifications

Entity Responsible for Verification:

- The Participant,
- The Participant's Support Broker. and
- The Department of Health and Welfare (during retrospective quality assurance reviews).

Frequency of Verification:

Initial and annually, with during review of employment/vendor agreement.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Environmental Accessibility Adaptations include minor housing adaptations necessary to enable the participant to function with greater independence in their home, without which the participant would require institutionalization or have a risk to health, welfare, or safety as determined in the Level of Care evaluation. 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 necessary to accommodate the medical equipment and supplies required for the welfare of the participant, but must exclude those adaptations or improvements to the home which 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 which is the participant's principal residence and is owned by the participant or the participant's non-paid family, or
c. Portable or Non-Stationary Modifications. Portable or non-stationary modifications may be made when such modifications can follow the participant to their next place of residence or be returned to the Department.

The services under Environmental Accessibility Adaptations are limited to additional services not otherwise covered under the State Plan, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.

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	Environmental Accessibility Adaptations
Agency	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:

Individual

Provider Type:

Environmental Accessibility Adaptations

Provider Qualifications

License *(specify):*

Licenses or 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.

Certificate *(specify):*

Other Standard *(specify):*

Environmental Accessibility Adaptions are delivered through an executed provider agreement with the provider and Medicaid. 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 and Welfare

Frequency of Verification:

At least every two (2) years.

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 or 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.

Certificate *(specify):*

Other Standard *(specify):*

Environmental Accessibility Adaptions are delivered through an executed provider agreement with the provider and Medicaid. 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 and Welfare

Frequency of Verification:

At least every two 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:

Home Delivered Meals

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home Delivered Meals are designed to promote adequate participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who:
a. Rent or own their own home;
b. Are alone for significant parts of the day;
c. Have no regular caretaker for extended periods of time; and
d. Are unable to prepare a meal without assistance.

This service will not constitute a full nutritional regimen.

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):*

The agency or business is inspected and licensed as a food establishment by the District Health Department.

Other Standard *(specify):*

Providers must be a public agency or private business and must be capable of:

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 under the service plan, in a sanitary manner, and at the correct temperature for the specific type of food;

c. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and

~~a.~~d. The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, "Idaho Food Code."

~~a. Supervising the direct service;~~

~~b. Providing assurance that 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;~~

~~c. Delivering the meals in accordance with the plan for care, in a sanitary manner, and at the correct temperature for the specific type of food; and~~

~~d.~~a. ~~Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served.~~

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

At least every two (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:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Non-Medical Transportation (NMT) enables a waiver participant to gain access to waiver and other community services and resources.

a. NMT is offered in addition to medical transportation required under 42 CFR 431.53 and 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 used.

For participants receiving NMT under the traditional plan, payment for NMT is limited to costs of needed to access this service or other activities and resources identified in a participant's Service Plan.

For participants on the Self-Directed option, the participant must stay within their prospective individual budget amount and services must be cost effective when comparing to comparing reasonable alternatives.~~there are no limits on the amount, frequency, or duration of these services other than the participant must stay within their prospective individual budget amount.~~

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	Community Support
Individual	Community Support
Individual	Non-Medical Transportation
Agency	Non-Medical Transportation

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:

Community Support

Provider Qualifications

License *(specify)*:

Driver's License

Certificate *(specify)*:

Other Standard *(specify)*:

Non-Medical Transportation providers must possess valid vehicle insurance and must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and a statement of qualification to provide identified supports.

Only participants who select the Self-Directed option may use this provider type.

Verification of Provider Qualifications

Entity Responsible for Verification:

- The Participant,
- The Participant's Support Broker. and
- The Department of Health and Welfare (during retrospective quality assurance reviews).

Frequency of Verification:

Initial and annually, during review of employment/vendor agreement.

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:

Community Support

Provider Qualifications

License *(specify):*

Driver's License

Certificate *(specify):*

Other Standard *(specify):*

Non-Medical Transportation providers must possess valid vehicle insurance and must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and a statement of qualification to provide identified supports.

Only participants who select the Self-Directed option may use this provider type.

Verification of Provider Qualifications

Entity Responsible for Verification:

- The Participant,
- The Participant's Support Broker. and
- The Department of Health and Welfare (during retrospective quality assurance reviews).

Frequency of Verification:

Initial and annually, during review of employment/vendor agreement.

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:

Non-Medical Transportation

Provider Qualifications

License *(specify):*

Driver's License

Certificate *(specify):*

Other Standard *(specify):*

Non-Medical Transportation providers must possess valid vehicle insurance.

Only participants who select the Traditional option may use this provider type.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

Annually

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:

Non-Medical Transportation

Provider Qualifications

License *(specify):*

Driver's License

Certificate *(specify):*

Other Standard *(specify):*

Non-Medical Transportation providers must possess valid vehicle insurance.

Only participants who select the Traditional option may use this provider type.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Personal Emergency Response System (PERS) is an electronic device that enables waiver participants 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.

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

Installation of the equipment is provided and is billed as a separate item under this waiver service. Maintenance and upkeep are furnished by the supplier.

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):*

Providers must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

At least every two (2) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Skilled Nursing

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Skilled Nursing services consist of intermittent or continuous oversight, training, or skilled care which is within the scope of the Nurse Practice Act (https://ibn.idaho.gov/practice/) and as such care must be provided by a licensed registered nurse (RN), or licensed practical nurse (LPN) under the supervision of a RN, licensed to practice in Idaho. Nursing Services must be referred by a physician or other practitioner of the healing arts. Nursing services may include:
a. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material;
b. The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning;
c. Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis;
d. Injections;
e. Blood glucose monitoring; and
f. Blood pressure monitoring.

Skilled Nursing services are authorized when the participant's needs exceed the level of care provided under the State Plan Personal Care Services (PCS). Intermittent or continuous oversight and training refers to the Supervisory RN who must oversee LPN services. Additionally, training may be provided to natural supports of the participant, so they may properly assist with tasks such as transferring participants whether a nurse is on site or not.

The state's Private Duty Nursing (PDN) service is provided under a 1901~~5~~(a) State Plan benefit which is excluded from, and not payable under, this waiver service.

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:

For participants on the Self-Directed option, the participant must stay within their prospective individual budget amount and services must be cost effective when comparing to comparing reasonable alternatives.~~there are no limits on the amount, frequency, or duration of these services other than the participant must stay within their prospective individual budget amount.~~

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	Community Support
Individual	Community Support
Agency	Skilled Nurse
Individual	Skilled Nurse

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:

Community Support

Provider Qualifications

License *(specify):*

Skilled Nursing providers must be licensed in Idaho as a Registered Nurse (R.N.) or Licensed Professional Nurse (L.P.N.) in good standing or must be practicing on a federal reservation and be licensed in another state.

Certificate *(specify):*

Other Standard *(specify):*

Skilled Nursing providers must adhere to requirements specified in IDAPA 24.34.01, "Rules of the Idaho Board of Nursing" and must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and a statement of qualification to provide identified supports.

Only participants who select the Self-Directed option may access this provider type.

Verification of Provider Qualifications

Entity Responsible for Verification:

- The Participant
- The Participant's Support Broker, and
- The Department of Health and Welfare (during retrospective quality assurance reviews).

Frequency of Verification:

Initial and annually, during review of employment/vendor agreement.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Individual

Provider Type:

Community Support

Provider Qualifications

License *(specify):*

Skilled Nursing providers must be licensed in Idaho as a Registered Nurse (R.N.) or Licensed Professional Nurse (L.P.N.) in good standing or must be practicing on a federal reservation and be licensed in another state.

Certificate *(specify):*

Other Standard *(specify):*

Skilled Nursing providers must adhere to requirements specified in IDAPA 24.34.01, "Rules of the Idaho Board of Nursing" and must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and a statement of qualification to provide identified supports.

Only participants who select the Self-Directed option may access this provider type.

Verification of Provider Qualifications

Entity Responsible for Verification:

- The Participant
- The Participant's Support Broker, and
- The Department of Health and Welfare (during retrospective quality assurance reviews).

Frequency of Verification:

Initial and annually, during review of employment/vendor agreement.

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:

Skilled Nurse

Provider Qualifications

License *(specify):*

Skilled Nursing providers must be licensed in Idaho as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) in good standing or must be practicing on a federal reservation and be licensed in another state.

Certificate *(specify):*

Other Standard *(specify):*

Skilled Nursing providers must adhere to requirements specified in IDAPA 24.34.01, "Rules of the Idaho Board of Nursing."

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

At least every two (2) years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Individual

Provider Type:

Skilled Nurse

Provider Qualifications

License *(specify):*

Nursing Service Providers must be licensed in Idaho as an R.N. or L.P.N. in good standing, or must be practicing on a federal reservation and be licensed in another state.

Certificate *(specify):*

Other Standard *(specify):*

Nursing service providers must adhere to requirements specified in IDAPA 24.34.01, "Rules of the Idaho Board of Nursing."

Only participants who select the Traditional option may use this provider type.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

At least every two (2) years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized Medical Equipment and Supplies includes devices, controls, or appliances which enable recipients to increase their abilities to perform activities of daily living, to ensure health or safety, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State Plan and exclude any items that are not of direct medical or remedial benefit to the recipient.

Requests for Specialized Medical Equipment are reviewed on a case-by-case basis and may include the costs of maintenance and upkeep of equipment, or the training of the participant or caregivers in the operation and/or maintenance of the equipment.

Specialized Medical Equipment and Supplies that can be covered under the State Plan should be furnished as services required under Early Periodic Screening, Diagnosis, and Treatment (EPSDT) to waiver participants under age twenty-one (21).

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

For participants on the Self-Directed option, the participant must stay within their prospective individual budget amount and services must be cost effective when comparing to comparing reasonable alternatives.~~there are no limits~~

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
Individual	Community Support
Agency	Community Support

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 Supplier provider types. Providers must ensure all items meet applicable standards of manufacture, design, and installation. Preference is given to equipment and supplies that are the most cost-effective option to meet the participant's needs.

Only participants who select the Traditional option may use this provider type.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

At least every two (2) years.

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:

Individual

Provider Type:

Community Support

Provider Qualifications

License *(specify):*

When required to provide identified goods or supports.

Certificate *(specify):*

Other Standard *(specify):*

Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and a statement of qualification to provide identified supports.

Only participants who select the Self-Directed option may access this provider type.

Verification of Provider Qualifications

Entity Responsible for Verification:

- The Participant
- The Participant's Support Broker, and
- The Department of Health and Welfare (during retrospective quality assurance reviews).

Frequency of Verification:

Initial and annually, during review of employment/vendor agreement.

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:

Community Support

Provider Qualifications

License *(specify):*

When required to provide identified goods or supports.

Certificate *(specify):*

Other Standard *(specify):*

Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and a statement of qualification to provide identified supports.

Only participants who select the Self-Directed option may access this provider type.

Verification of Provider Qualifications

Entity Responsible for Verification:

- The Participant
- The Participant's Support Broker, and
- The Department of Health and Welfare (during retrospective quality assurance reviews).

Frequency of Verification:

Initial and annually, during review of employment/vendor agreement.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transition Services

HCBS Taxonomy:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Transition Services include non-recurring set-up expenses that enable a participant residing in a qualified institution to transition to a community-based setting where the person is directly responsible for their own living expenses. Although a participant is eligible to receive Transition Services after residing within a qualified institution for a minimum of forty-five (45) Medicaid-reimbursed days and eligibility under this waiver is determined, the costs of Transition Services are only considered to be incurred and billable when the person leaves the qualified institution and enters the waiver.

Qualified institutions include the following:
• Skilled, or Intermediate Care Facilities;
• Nursing Facilities;
• Licensed Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/IID);
• Hospitals; and
• Institutions for Mental Diseases (IMD).

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

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

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

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

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

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

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	Community Support
Individual	Community Support
Agency	Transition Manager

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Agency

Provider Type:

Community Support

Provider Qualifications

License *(specify):*

When required to provide identified goods or supports.

Certificate *(specify):*

Other Standard *(specify):*

Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and a statement of qualification to provide identified supports.

Only participants who select the Self-Directed option may access this provider type.

Verification of Provider Qualifications

Entity Responsible for Verification:

- The Participant
- The Participant's Support Broker, and
- The Department of Health and Welfare (during retrospective quality assurance reviews).

Frequency of Verification:

Initial and annually, during review of employment/vendor agreement.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Individual

Provider Type:

Community Support

Provider Qualifications

License *(specify):*

When required to provide identified goods or supports.

Certificate *(specify):*

Other Standard *(specify):*

Must have completed employment/vendor agreement specifying goods or supports to be provided, qualifications to provide identified supports, and a statement of qualification to provide identified supports.

Only participants who select the Self-Directed option may access this provider type.

Verification of Provider Qualifications

Entity Responsible for Verification:

- The Participant
- The Participant's Support Broker, and
- The Department of Health and Welfare (during retrospective quality assurance reviews).

Frequency of Verification:

Initial and annually, during review of employment/vendor agreement.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Agency

Provider Type:

Transition Manager

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Transition Managers arrange for and procure Transition Services. All providers of Transition Services must:
•Satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks";
• Successfully complete the Department-approved Transition Manager Training prior to providing any Transition Services;
• Hold a Bachelor's Degree in a human services field from a nationally accredited university or college; or three (3) years' supervised work experience with the population being served; and
• Be employed with a provider type approved by the Department.

Only participants who select the Traditional option may use this provider type.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Welfare

Frequency of Verification:

At least every two (2) years.

Appendix C: Participant Services

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

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:

  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*
  - ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Case Managers in both the traditional and consumer-directed options ensure that participants or their decision-making authority direct the development of their Service Plan through a person-centered planning process. The Case Manager provides information and support to the participant maximizing their ability to make informed choices and decisions.

1. Participants selecting traditional waiver services receive Case Management through Service Coordination as described in IDAPA 16.03.10.720 through 736~~779~~. Service Coordination assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. Service Coordination includes plan assessment and periodic re-assessment, plan development, referral activities, monitoring activities ensuring the plan is implemented and adequately addresses the participant's needs and crisis assistance. In order to ensure there is no conflict of interest, Service Coordinators may not provide both Service Coordination and direct services to the same participant and must ensure employees and contractors meet the conflict-of-interest standards described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 721.

2. Participants selecting Consumer-Directed Services receive Case Management through a Support Broker as described in IDAPA 16.03.13.135 -136. A Support Broker is advocates on behalf of the participant and is hired by the participant to assist with planning, negotiating, and budgeting. Support Broker Services may include only a few required tasks or be provided as a comprehensive service package depending on the participant's needs and preferences. At a minimum, the Support Broker must:
a. Participate in the person-centered planning process,
b. Develop a written Support and Spending Plan (SSP) with the participant that includes the paid and unpaid supports that the participant needs and wants, related risks identified
with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three (3) back-up plans should a support fail. This
plan must be authorized by the Department,
c. Assist the participant with monitoring and reviewing their budget,
d. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department,
e. Participate with Department quality assurance measures, as requested,
f. Assist the participant with completing the annual re-determination process as needed, including updating the SSP and submitting it to the Department for authorization,
g. Assist the participant, as needed, with meeting participant responsibilities,
h. Assist the participant, as needed, with protecting their own health and safety, and
i. Complete the Department-approved criminal history check waiver form when a participant chooses to waive the criminal history check requirement for a community support worker; and
j. Meet the conflict-of-interest standards described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 721.

In addition to the required Support Broker duties, each Support Broker must provide the following services when requested by the participant:
a. Assist the participant with developing and maintaining a circle of support,
b. Help the participant learn and implement the skills needed to recruit, hire, and monitor Community Supports,
c. Assist the participant with negotiating rates for paid Community Support Workers,
d. Maintain documentation of supports provided by each Community Support Worker and the participant's satisfaction with these supports,
e. Assist the participant with monitoring Community Supports,
f. Assist the participant with resolving employment-related problems, and
g. Assist the participant to identifying and developing community resources to meet specific needs~~.~~
~~g.~~h. Assist the participant in distributing the support and spending plan to community support workers or vendors.

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):

All traditional waiver service providers of direct care or services to participants must satisfactorily complete a criminal history and background check (completed by the Department's Criminal History Unit) in accordance with IDAPA 16.05.06, "Criminal History and Background Checks."

Criminal History Checks review information obtained from the Federal Bureau of Investigation, the National Criminal History Background Check System, the Idaho State Police Bureau of Criminal Identification, the Adult Protection Registry, the Sexual Offender Registry, and the Medicaid Surveillance and Utilization Review Exclusion List.

Traditional waiver service providers sign a written agreement to comply with all rules and regulations relevant to the services they provide including compliance with IDAPA 16.05.06. Criminal history background checks are also reviewed during retrospective quality assurance surveys conducted by the Department.

Participants selecting Consumer-Directed Services may choose to waive the criminal history and background check for Community Support Workers. When a participant chooses to waive this requirement, they must document their choice in writing and the Fiscal Employer Agent (FEA) must maintain this document. The documentation of the waived criminal history and background check requires that the Support Broker documents education and counseling provided to the participant and their circle of support regarding the risks of waiving a criminal history check and that the Support Broker assisted with detailing the reason for waiving the criminal history check. The participant, the legal guardian (if applicable) and Support Broker must sign this documentation. The documentation must state:

1. Why the participant is waiving the criminal history check,
2. How the participant will assure health & safety without obtaining the criminal history check, and
3. That the participant understands the risk with waiving the criminal history check and accepts this increased risk.

Additionally, the Department monitors criminal history and background check waivers for participants who selected Consumer-Directed Services in the following ways:

• Conducting participant experience surveys that include a sampling of participants who waived the criminal history check for a Community Support Worker,
• Receiving a list of criminal history check waivers from the FEA,
• Conducting a search of the Complaint/Incident Database for any complaints or incidents associated with the participants and their Community Support Workers with a criminal history check waiver, and
• Providing Quality Oversight Reports to the Quality Oversight Committee that include an analysis of the impact of this waiver process.

Criminal History and Background Checks are required of all Support Brokers for participants selecting Consumer-Directed Services. Prior to reimbursement, the Support Broker and Community Support Workers, must submit a copy of the clearance letter received from the Department's Criminal History Check Unit or a copy of the completed criminal history background check waiver, as applicable.

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):

The Idaho Commission on Aging maintains the Adult Protection Registry.

Providers who must receive criminal history checks also must be screened using the Adult Protection Registry. Criminal History and Background Checks, completed by the Department's Criminal History Unit, include a review of the abuse registries.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

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.**

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

◉ **Other policy.**

Specify:

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 Support Brokers who must not be the guardian, parent, spouse, payee, or conservator of the participant. 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, Fiscal Employer Agents (FEA), and by the Department through review and approval of proposed plans of care and retrospective quality assurance reviews.

All providers are precluded from being in a position to both influence a participant's decision making and benefit financially from these decisions. Payments for services rendered are made only after review and approval by the participant and review by the Fiscal Employer Agent (FEA). Additionally, the participant's Support Broker and circle of supports are available to address any conflicts of interest.

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 a Request for Proposal (RFP) process limiting the number of providers and do not have additional contracting requirements or other qualifications 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 the state's Medicaid Management Information System (MMIS) through an electronic application form. Provider enrollment help is available through a toll-free number given to interested provider applicants. Providers with additional questions may contact the local Medicaid office or Medicaid Program Manager designated to assist with provider enrollment issues.

Lists of current providers are available from the Independent Assessment Contractor (IAP) and in regional Department offices. Provider qualifications and requirements are published in the Department's Administrative Rules and are available online at https://adminrules.idaho.gov/rules/current/16/. Specific Medicaid provider information, including provider handbooks and provider enrollment information, is available on the MMIS website at https://www.idmedicaid.com/default.aspx.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States

methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of initial licensed/certified (L/C) waiver providers requiring L/C standards and adhere to other standards prior to providing services. a. Numerator: Number of initial L/C waiver providers that meet L/C standards and adhere to other standards prior to providing services. b. Denominator: Number of initial waiver providers requiring L/C and adherence to other standards.

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

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

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of ongoing providers that meet Licensure/Certification (L/C) standards. a. Numerator: Number of ongoing providers that meet L/C standards. b. Denominator: Number of ongoing waiver providers surveyed.

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

Responsible Party for	**Frequency of data**	**Sampling Approach**

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Residential habilitation providers are surveyed when they seek renewal of their certificate. The Department issues certificates that are in effect for a period of no longer than three years	

Data Aggregation and Analysis:

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

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

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:
 # and % of initial, non-licensed/certified (non-L/C) providers that received an initial provider review within 6 mo. of providing services & demonstrated adherence to waiver requirements. a. Num: # of initial, non-L/C providers that received an initial provider review within 6 mo. of providing services & demonstrated adherence to waiver requirements. b. Den: # of initial, non-L/C providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Both On-Site and Off-Site Record Reviews

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of licensed/non-certified (non-L/C) waiver providers that received a quality review every two years and meet waiver requirements. a. Numerator: Number of non-L/C waiver providers that received a quality review every two years and meet waiver requirements. b. Denominator: Number of non-L/C d waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Both On-Site and Off-Site Record Reviews

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

Data Aggregation and Analysis:

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

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
Number and percent of waiver providers that meet state requirements for training. a. Numerator: Number of waiver providers that meet state requirements for training. b. Denominator: Number of waiver providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Both On-Site and Off-Site Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Providers who are not certified are surveyed every two years. The Department issues certificates for certified providers that are in effect for a period of no longer than three years.	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

The Medicaid Bureau of Developmental Disability Services (BDDS) Quality Manager is responsible for Quality Assurance QA remediation and system improvement processes and reporting.

BDDS QA staff address individual problems as they are discovered, and document this work in a database for tracking all provider-related information. When provider deficiencies are identified, BDDS QA staff, at their discretion, take any of the following actions for cause based on the provider's conduct or the conduct of its employees or agents, or when the provider fails to comply with any term or provision of the Provider Agreement, or any applicable state or federal regulation:
• Require a corrective action plan to be submitted by the provider to address noncompliance with the provider agreement;
• Reduce, limit, or suspend payment of claims pending the submission, acceptance, or completion of a corrective action plan;
• Limit or suspend provision of services to participants who have not previously established services with the provider pending the submission, acceptance, or completion of a corrective action plan; or
• Terminate the Provider's Agreement.

The BDDS Quality Oversight Committee, (comprised of the BDDS Bureau Chief, BDDS Quality Manager, BDDS Operations Managers, State Licensing & Certifications (L&C) staff, Medicaid Contract Monitors, Medicaid Policy Staff) review data and Annual BDDS Level of Care (LOC) Report findings, identifies remediation activities, and monitors of ongoing system improvement initiatives and activities.

The Medicaid BDDS Management Team identifies and addresses any statewide resource or program issues identified in QA business processes and analyzed reports. The BDDS Management Team reports the analysis to the BDDS Bureau Chief who then recommends program changes or system improvement processes to the Central Office Management Team (COMT) for approval.

Medicaid's COMT reviews BDDS and all other Medicaid program report analyses and recommendations and considers Division-wide resources and coordination issues and strategies when making final system wide change decisions.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the

amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☒ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

A calculation tool establishes a budget based on information entered on an Inventory of Individual Needs, an assessment tool designed to capture the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to their developmental disability. The tool is based on a regression analysis model which calculates a budget that correlates with each participant's individualized needs.

The budget tool is periodically evaluated and adjusted to ensure participant budgets are calculated using information that produces the greatest statistical validity when analyzing participant need and cost of services.

To ensure a participant's budget is adequate to meet their individual needs, Idaho provides the following safeguards:

1. When the participant receives notice regarding their budget amount, they may appeal that budget within twenty-eight (28) days of the date on the eligibility notice. When the appeal is received, the Department reviews to ensure all the participant's needs were accurately captured through responses on the inventory of individual needs, and that the participant does not have needs outside of what is captured by the inventory that meet medical necessity criteria. If there are medically necessary services that are needed to ensure a participant's health and safety, but the need for such service is not addressed by the inventory, dollars to meet those needs are added to the budget. Individualized budgets are re-evaluated annually.

2. At the request of the participant, the Department also re-evaluates the set budget amount when there are documented changes in the participant's condition resulting in a need for services that meet medical necessity criteria, are necessary to ensure a participant's health and safety, and is not reflected on the current inventory of individual needs. When the Department determines there has been a documented change in condition not reflected on the current inventory, a new inventory is completed, and budget calculated for the participant. The participant has the right to appeal this new budget.

3. A participant may submit a Service Plan requesting a combination of services that exceeds their annual calculated budget when the request for additional budget dollars is associated with services to address a health or safety concern (including access challenges related to hiring/maintaining qualified Community Support Workers) or to obtain/maintain employment that meets criteria defined in Department rule. The participant, their person-centered planning team and Plan Developer identify which services are needed to meet the participant's assessed needs at the time of annual plan development or when a Service Plan is adjusted during the year. If, through these processes, it is identified that a participant may require a budget modification to address a health or safety concern or to maintain/obtain employment, the Plan Developer assists the participant with requesting an Exception Review. For participants requesting an Exception Review, Plan Developers submit a Department-approved Exception Review form and supporting documentation along with the annual plan of service or addendum. Exception Review requests are reviewed and approved by Department Case Managers based on the following:

a. Supported Employment Exception Review. A Supported Employment service recommendation including the recommended amount of service, level of support needed, employment goals, and a transition plan designed to facilitate the participant's independence in their work environment which includes criteria on how the participant will transition to less dependence on paid supports. The Supported Employment recommendation shall accompany the Exception Review Request and must be completed by the Idaho Division of Vocational Rehabilitation (IDVR) when the participant transitions from IDVR services or by the Supported Employment Agency identified on the plan of service or addendum. The participant's plan of service has been developed by the participant and their person-centered planning team to support employment as a priority. Exception Reviews submitted with an addendum should include service modifications to accommodate the addition or increase of Supported Employment services. If no service modifications are made to accommodate the addition or increase of Supported Employment services, the person-centered planning team identifies the reasons for the ongoing need for the requested mix of services. Acknowledgement that additional budget dollars approved to purchase Supported Employment services may not be reallocated to purchase any other Medicaid service signed by the participant and legal guardian if one exists.
b. Health Risk Exception Review – A need for a service to prevent a participant’s physical health, mental

health, or cognitive functioning from deteriorating or to prevent an increase to a participant's maladaptive behavior. A description of the health risk and which services or supports are requested in relation to the health risk. Health risks must be established through written documentation and current treatment recommendations from a licensed practitioner of the healing arts as defined in IDAPA or other professionals licensed by the State of Idaho whose recommendation for the specific support or services being requested is within the scope of their license. Such documentation must establish: (1) the current physical or mental condition or cognitive functioning that will likely deteriorate, or the current maladaptive behavior(s) that will likely increase; and (2) the specific supports or services being requested that will address the identified need and how those supports or services will prevent the health risk.

c. Safety Risk Exception Review – A need for a service to prevent a participant from engaging in criminal behavior, destruction of property, or the harm to themselves or others. A description of the safety risk and what services or supports are requested in relation to the safety risk. Safety risks must be documented by the following: (1) current incident reports; (2) police reports; (3) assessments from a licensed practitioner of the healing arts as defined by IDAPA or a professional licensed by the State of Idaho and whose assessment is within the scope of their license; or (4) status reports and implementation plans reflecting the type and frequency of intervention(s) in place to prevent the risk and the participant's progress under such intervention(s). Such documentation must establish: (1) an imminent or likely safety risk; and (2) the specific supports or services requested (including the type and frequency, if applicable) that are likely to prevent that risk, and how those supports or services will likely prevent this risk.

Requests for an exception review of annual plans must be submitted within forty-five (45) days prior to the expiration of the existing plan. Adjustments to the plan of service can be made throughout the year through an addendum to the plan of service. Requests for an Exception Review for addendums must be submitted fifteen (15) days prior to the anticipated start date of the modified service.

☐ **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.

The State Medicaid Agency (SMA) has implemented the Home and Community-Based Settings (HCBS) Final Rule standards to establish compliance with HCBS settings requirements. The SMA has also implemented robust ongoing monitoring activities ensuring ongoing compliance. Monitoring is in place to ensure all HCBS settings are following state rules and all HCBS criteria allowing for integration and choice in the setting where individuals access HCBS.
The HCBS Settings Final Rule implementation methods and ongoing monitoring activities for all HCBS settings criteria are described below:

A. Idaho Administrative Code (IDAPA) Rule Promulgation: The SMA codified HCBS setting qualities and person-centered service plan and planning requirements into state administrative code under 16.03.10 "Medicaid Enhanced Plan Benefits", implemented effective July 1, 2017. State rules address a variety of HCBS setting requirements the SMA monitors for ongoing compliance such as HCBS setting qualities, residential provider-owned or controlled settings, and HCBS planning requirements.

B. Internal Policies and Procedures: Internal SMA documents have been updated to include new regulatory criteria. Process manuals for conducting provider audits and supplemental tools have been modified to include a review of setting qualities and person-centered service planning compliance (as applicable to the provider type/service type). Onboarding processes and training materials for new SMA staff have been updated to include orientation to the HCBS regulatory requirements and associated job-specific tasks.
Person-Centered Planning processes have been strengthened to ensure that participants and their decision-making authority have a choice of when and where their services are received. Additional fields have been added to several documents produced by the state, including service plan templates, to ensure that HCBS setting elements are not overlooked.

C. Provider/Settings Enrollment: State administrative code in 16.03.10 "Medicaid Enhanced Plan Benefits" states that new HCBS providers or service settings are expected to fully comply with the HCBS requirements and qualities as a condition of becoming a Medicaid provider. Prior to approval of new enrollment applications, the SMA evaluates HCBS compliance for the following provider types: Adult Day Health, CFHs, DDAs, Residential Habilitation agencies~~Supported Living~~, Supported Employment, Nursing Services, Respite Services, and Behavioral Consultation/Crisis Management. Documents reviewed for HCBS settings compliance prior to approval as a Medicaid HCBS provider or setting include the provider application, template notices, template intake packets, and policies and procedures.

D. Provider Training Materials: Public-facing materials for provider reference, including new provider onboarding materials, have been updated to include HCBS setting quality and person-centered planning requirements.

E. Licensing and Certification: The SMA Licensing and Certification (L&C) staff assess compliance with all HCBS requirements when completing their routine surveys of HCBS providers. L&C reviews the following HCBS regulations: integration and access, selection of setting, participant rights, autonomy and independence, choice, written agreement, privacy, schedules and activities, access to food, visitors, and physical accessibility. Surveys are completed every six (6) months to three (3) years, depending on provider type and status.

F. Provider Quality Reviews: SMA Quality Assurance Specialists (QA) continue to complete provider quality reviews. Existing Provider Quality Review processes have been modified to include components specific to HCBS compliance. QA Specialists have been trained to offer collaboration to non-compliant providers, in the form of technical assistance, onsite meetings, or other methods as defined by the SMA. Provider reviews are completed every six (6) months to three (3) years, depending on provider type and status.

G. Complaints and Critical Incidents: Complaint and critical incident management systems have been modified to include a category specific to HCBS setting qualities and service plan-related issues. Regular trend monitoring activities have been updated to include oversight of these regulatory criteria.

H. Participant Feedback Mechanisms: Existing participant feedback mechanisms have been modified to include targeted questions about HCBS compliance in the participant's service setting. The Adult Service Outcome Review (ASOR) is used to assess services provided to participants of this benefit. The ASOR Templates and Instruction Manual were revised in 2018 to incorporate HCBS requirements.

I. Service Plan Review: SMA BDDS Care Managers review all service plans prior to authorization and annually thereafter to ensure that only HCBS-compliant settings are selected for identified services. They ensure that all components of the person-centered plan are completed accurately. SMA BDDS Care Managers confirm all services and settings are chosen by the participant or their decision-making authority as evidenced by their signature on the person-centered service plan. Service providers also sign the plan acknowledging they will deliver services according to the authorized plan of service and consistent with HCBS requirements.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individual Support Plan or Support and Spending 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:

Initial and annual Plan Development on this waiver is provided to all participants according to whether they choose to receive waiver services via the Traditional Model, or the Self-Directed Model as described below.

A. Traditional Model.
For individuals selecting traditional waiver services, paid Plan Developers must meet Service Coordination qualifications as defined in IDAPA 16.03.10.729. Neither a provider of direct service to the participant nor the Independent Assessment Contractor (IAC) may be chosen to be the paid Plan Developer. Paid Plan Development for participants on the Traditional Model is prior authorized through the State Plan as indicated on the published fee schedule. Plan Development is not a service on this waiver.

A Service Coordinator providing services to a participant accessing traditional Waiver services must meet the following qualifications:
• Service Coordinators must be employees or contractors of an agency with a valid provider agreement with the Department; and
• Minimum of a Bachelor's degree in human services field from a nationally accredited university or college and have twelve (12) months supervised work experience with the
population being served; or be a licensed professional nurse (LPN); and have twelve (12) months' work experience with the population being served. When an individual meets
the education or licensing requirements but does not have the required supervised work experience, the individual must be supervised by a qualified Service Coordinator while
gaining the required work experience; and
• Service Coordination agencies must verify that each Service Coordinator and paraprofessional they employ or contract complies with requirements in IDAPA 16.05.06, Criminal
History and Background Checks.; and
• Service Coordination agencies must ensure its employees and contractors meet the conflict of interest standards described in IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits,”
Section 721.03; and
• The total caseload of a Service Coordinator must assure quality service delivery and participant satisfaction.

B. Self-Directed Model
For individuals selecting Consumer Directed Services, Plan Development is completed by the Support Broker. Support Brokers must meet qualifications as defined in IDAPA 16.03.13.135. Neither a provider of direct service to the participant nor the Independent Assessment Contractor (IAC) may be chosen to be the paid Plan Developer.
A Support Broker providing services to a participant accessing Consumer Directed Services must meet the following qualifications:
• Be eighteen (18) years of age or older;
• Have skills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field;
• Have at least two (2) years verifiable experience with the target population and knowledge of services and resources in the developmental disabilities field ;
• Successfully pass a Department-administered application exam containing proctored exam questions on the state’s developmental disability programs and a case study for each
population for which the Support Broker intends to provide services;
• Complete a criminal history check, including clearance in accordance with IDAPA 16.05.06, “Criminal History and Background Checks”; and
• Complete an employment agreement with the participant that identifies the specific tasks and services that are required of the Support Broker.

All Support Brokers must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of Support Broker services.

The Support Broker must not be the guardian, parent, spouse, payee, or conservator of the participant, or have direct control over the participant’s choices. Additionally, the Support Broker must not be in a position to both influence a participant's decision making and receive undue financial benefit from the participant’s decisions (IDAPA 16.03.13 “Consumer-Directed Services,” Section 1305.025; and must meet the conflict of interest standards described in IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits,” Section 721.03 and Section 728.07-08.

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.

During the assessment process, participants receive a list, organized by geographic area, of Plan Developers in the State of Idaho. The list also includes website links providing helpful resources for participants, guardians, family members, and person-centered team members. Participants also receive additional information about traditional service and Consumer-Directed Service options. For families interested in Consumer-Directed Services, the Department offers an orientation and a "My Voice, My Choice" training.

For participants selecting traditional waiver services, the participant or their decision-making authority directs the development of their Service Plan through a person-centered planning process. The Plan Developer provides information and support to the participant maximizing their ability to make informed choices and decisions. The participant or the participant's decision-making authority identifies individuals invited to participate in the person-centered planning process.

Participants selecting Consumer-Directed Services choose a qualified Support Broker to assist with writing their Support and Spending Plan (SSP). As outlined in IDAPA 16.03.13, "Consumer-Directed Services," the participant decides who participates in the planning sessions in order to ensure their choices are honored and promoted. The participant directs the development of their Service Plan. The participant may choose to facilitate their person-centered planning meetings, or have the meetings facilitated by their chosen Support Broker.

In addition, the participant selects a circle of support. Members of the circle of support commit to work within the group to help promote and improve the life of the participant in accordance with the participant's choices and preferences and meet on a regular basis to assist the participant with accomplishing their expressed goals.

With respect to the Supported Employment, the Division of Medicaid, in coordination with the Council on Developmental Disabilities, Division of Vocational Rehabilitation, Disabilities Rights of Idaho, and Vocational Services of Idaho communicate to participants, Plan Developers, and Supported Employment providers that the Exception Review process includes budget modifications when additional funds are needed to obtain or maintain employment.

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):

TAfter the Department notifies each participant of their set budget amount as part of the eligibility determination process or annual determination process., the participant determines if they want to select traditional waiver or Consumer-Directed Services.

For participants selecting traditional waiver services, the participant or their decision-making authority directs the development of their Individual Service Plan (ISP) through a person-centered planning process with a Plan Developer (Service Coordinator). For participants who select Consumer-Directed Services, the participant or their decision-making authority directs the development of their SSPISP through a person-centered planning process with a Plan Developer (Support Broker) and their circle of support.

The number of people who can be involved is not limited. The participant, the Plan Developer, and their decision-making authority (if applicable) are required to be a part of plan development process.

For participants selecting traditional waiver services, each ISP must be submitted to the Department at least forty-five (45) days prior to the expiration of the current ISP in accordance with IDAPA 16.03.10.513.02704. The Department has thirty (30) days to review the plan, discuss any issues with the Plan Developer (Service Coordinator), and request changes as needed. The Plan Developer (Service Coordinator) discusses identified plan review issues with the participant and their decision-making authority (if applicable). The Department enters the authorizations for approved services into the Medicaid Management Information System (MMIS) within fifteen (15) days.

Participants selecting Consumer-Directed Services submit their Support and Spending Plan (SSP) directly to the Department for review and authorization. The Department reviews the plan, discusses any issues with the Plan Developer (Support Broker), and requests changes as needed within forty-five (45) days. The Plan Developer (Support Broker) discusses identified plan review issues with the participant and their decision-making authority (if applicable). The Department enters the authorizations for approved services into the MMIS system within five (5) days.

The participant receives a written notification of plan approval or denial. As part of this notification, participants receive information on how to appeal the Department's decision.

The Independent Assessment Contractor (IAC) conducts and collects a variety of assessments and determines the participant's individualized budget at the time of initial application and on an annual basis. These assessments are used to secure information and support the ISP/SSP development process.

At the time of initial application for waiver services, the IAC conducts and/or obtains the following assessments:
• Functional assessments - Scales of Independent Behavior-Revised (SIB-R),
• Medical, social, and developmental assessment summary, and
• Physician's health and physical from the participant's Primary Care Physician.

At the time of the annual re-determination, the IAC reviews and/or updates the following:
• SIB-R results are reviewed, and another assessment is conducted when reassessment criteria is met,
• The medical, social, and developmental assessment summary, and
• A health and physical. This information is required and provided to the IAC on an annual basis.

The following assessments may be obtained as needed to determine initial level of care eligibility and to calculate an individual budget:
• Psychological evaluations,
• Supplemental Medical Assessments, and
• Risk Assessments.

Participants, guardians, and other members of the support team receive information regarding waiver services through several methods:
• The Department of Health and Welfare's web site (https://healthandwelfare.idaho.gov/services-programs/medicaid-health/services-adults-developmental-disabilities) provides a detailed explanation for each service provided under this Waiver.
• The IAC lists all waiver services with a description of what each service entails. During the eligibility process the IAC provides this information to the family and explains options to initial applicants.

• During the eligibility process, the IAC provides each new applicant with a Consumer Tool Kit which includes a listing of agencies in the local area that provide waiver services
• For participants selecting traditional waiver services, the Plan Developer and Service Coordinator verbally explain the various programs and options to the participant during the
person-centered planning process, under the traditional option.
• For participants selecting Consumer-Directed Services, the Support Broker assists the participant with assessing which services meet their needs.
Idaho requires following a person centered-planning process during Plan Development to ensure that participant goals, needs, and preferences are reflected on the ISP and on their
SSP. The Department develops an ISP manual for traditional waiver services and a Support Broker manual for Consumer-Directed waiver services for use by Plan Developers statewide. The manuals provide details on addressing participant goals, needs, and preferences. ~~An ISP manual developed by the Department is used by Plan Developers statewide. This manual provides details on addressing participant goals, needs, and preferences.~~

Participants selecting Consumer-Directed Services attend a "My Choice My Voice" training prior to submitting their first SSP. Completion of this training is documented in the Department's Quality Assurance (QA) database. The training covers participant responsibilities and the process of developing a SSP. The consumer-directed option uses the "My Voice My Choice Workbook" and a Support Broker to ensure that the participant's individual goals, needs, and preferences are thoroughly explored and prioritized during the plan development process.

Participants typically receive a variety of waiver services, State Plan services, and other supports to address their wants and needs. The person-centered planning team works to ensure that the plan adequately reflects all necessary services.

For participants selecting traditional waiver services, the Plan Developer and Department staff who authorize the plan ensure that services are coordinated.

• The Plan Developer works with the members of the person-centered planning team and providers to ensure that the service needs of the participant are reflected on the ISP.
• The Plan Developer ensures that services are not duplicative.
• Department staff review each ISP submitted by the Plan Developer to ensure that the participant's needs are addressed by the plan and services are not duplicative.

For participants selecting Consumer-Directed Services, the participant and their circle of supports use the "My Voice My Choice Workbook" and the person-centered planning process to identify participant needs and develop a SSP that meets those needs.

• The Support Broker writes the SSP reflecting the needs and wants of the participant.
• Department staff review the plan to ensure that all health and safety requirements are met.
• The Fiscal Employer Agent (FEA) ensures that duplication of payment does not occur.

Participants selecting traditional waiver services choose a Plan Monitor as outlined in IDAPA 16.03.10.513.05~~704~~. The person- centered planning team identifies the frequency of monitoring but at a minimum it must occur at least every ninety (90) days. In addition, the plan must be monitored for continuing quality. Plan Monitoring ensures that the ISP addresses the participant's goals, needs, and preferences by requiring:
• Making face-to-face contact with the participant at least every ninety (90) days to identify the current status of the program and changes if needed,
• Contacting service providers to identify barriers to service provision.,
• Discussing satisfaction regarding quality and quantity of services with the participant,
• Reviewing provider status reviews, and reports for annual plan development, and
• Reporting any suspicions or allegations of abuse, neglect or exploitation to the appropriate authorities, including the Department.

For p~~P~~articipants selecting Consumer-Directed waiver s~~S~~ervices, ~~may choose to complete~~ Plan Monitoring ~~themselves, use members of their circle of supports, or require their Support Broker to perform these duties. Plan Monitoring~~ is assigned during the person-centered planning process and is reflected in the "My Voice My Choice Workbook." The Support Broker monitors the implementation of the Service Plan (including effectiveness of back-up plans and access to non-waiver services) and health and welfare of participants who select consumer-directed waiver services. The participant and circle of supports determine the frequency and methods for monitoring.

At a minimum, a Support Broker meets face-to-face with the participant when providing the following required duties:

- Participating in the annual person-centered planning meeting,
- Assisting the participant with completing the annual re-determination process as needed, including updating the SSP

and submitting it to the Department for authorization.

Any other face-to-face contact outside of the Support Broker duties required by rule are at the discretion of the participant.

Each participant must submit a new plan annually. The IAC sends written notification 120 days prior to the expiration of the current plan. The notice requests that the participant, and anyone they choose to help or represent them, schedule a meeting with the IAC to begin the process of eligibility re-determination, annual budget determination, and plan development.

The ISP may be adjusted during the year with an addendum to the plan. These adjustments must be based on a change to a cost, addition of a service or increase to a service, or a change of provider, addition of a restrictive intervention, or addition of alone time. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department.

Requests for an Exception Review with an annual plan should be submitted with the plan at least forty-five (45) days prior to the expiration of the existing plan.

Adjustments to the plan of service can be made anytime throughout the year through an addendum/plan change to the Plan of Service. Addendums accompanied by a request for an Exception Review should be submitted fifteen (15) days prior to the anticipated start date of the modified service.

For both traditional services and consumer directed services, the person-centered planning process must:
• Be conducted annually, timely, and occur at convenient times and locations for the participant and the participant's decision- making authority,
• Reflect the participant's cultural considerations,
• Be conducted by providing information in plain language and in a manner accessible to participants with disabilities or with limited English proficiency as defined in 42 CFR
435.905(b).

Plan Developers ~~and Support Brokers~~ must, if needed, use strategies for solving conflict or disagreement within the process and follow clear conflict-of-interest guidelines for all participants.

All person-centered service plans must include:
• Clinical services and supports that are important for the participant's behavioral, functional, and medical needs as identified through an assessment,
• Indication of what is important to the participant with regard to their service providers and preferences for the delivery of their services and supports,
• Documentation of the Home and Community Based Settings (HCBS) selected by the participant or the participant's decision-making authority and indication the setting was chosen from
a variety of setting options. The person-centered Service Plan must identify and document the alternative HCBS options considered by the participant, or the participant's
decision-making authority,
• Participant's strengths and preferences,
• Individually identified goals and desired outcomes,
• Paid and unpaid services and supports who assist the participant achieve identified goals, and the providers of those services and supports, including natural supports,
• Risk factors to the participant as well as people around the participant and measures in place to minimize those risks, including individualized back-up plans and strategies when
needed,
• The name of the individual or entity responsible for monitoring the plan, and
• Documentation that the plan is finalized and agreed to, by the participant, or the participant's decision-making authority, in writing, indicating informed consent. The plan must
also be signed by all individuals and providers responsible for implementation indicating they agree to deliver services according to the authorized plan of service and consistent
with HCBS requirements.

All person-centered Service Plans must be understandable to the participant receiving services and supports, and the

individuals important in supporting them. At a minimum, the written plan must be understandable, and written in plain language in a manner that is accessible to participants with disabilities or limited English proficiency, consistent with 42 CFR 435.905(b). The plans are distributed to the participant and the participant's decision-making authority, if applicable, and others involved in the implementation of the plan.

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.

Person-Centered Planning and Plan Development.
The person-centered planning process includes risk assessment. Person-centered planning team members identify risks while developing the Individual Support Plan (ISP) for traditional waiver services or the Support and Spending Plan (SSP) for Consumer-Directed waiver services. The planning team identifies emergency back-ups and plans to mitigate identified risks for both types of service plans. To assist with identification of risks, the Department includes in each participant's ~~plan~~ISP/~~SSP~~ a health and safety checklist in the Personal Summary section.

Each Service Plan identifies risks or safety concerns in relation to the support needs identified in the plan. These concerns may include, but are not limited to, medical issues, supervision needs, abuse risks, risks that result from a participant's behavior issues, exploitation risks, and financial risks. If the health and/or safety of the participant is in immediate jeopardy in a specified situation, or if a natural or paid support does not arrive at the scheduled time to provide a support, a back-up plan must be developed for each risk and safety concern. For Consumer-Directed services, three (3) back-up plans must be developed for each risk and safety concern. Each back-up plan must identify the risk or safety concern, and how to manage each risk or safety concern (i.e., identify other ways a participant could obtain the help they need) should the specified risk or safety concern arise.

Community Crisis Supports.
For traditional services t~~T~~he Department also offers Community Crisis Supports. These supports include intervention for participants in crisis situations to ensure health and safety in the event of hospitalization, loss of housing, loss of employment or major source ~~reduction~~ of income, risk of incarceration, risk of physical harm to~~,~~ self or others, including family altercations or psychiatric relapse~~other emergencies specific to the participant~~. If a participant experiences a crisis, Community Crisis Supports can be authorized to assist the participant out of the crisis and develop a plan to mitigate risks for future instances.

Provider Agencies.
Provider agencies provide quality assurance and health and safety for the participants they serve. Provider Agreements and IDAPA rules require Medicaid providers to supply safe, effective services with processes in place to assure quality.

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.

During the assessment process, participants receive a list, organized by geographic area, of Service Coordination agencies in the State of Idaho who serve participants not enrolled in the Medicare Medicaid Coordinated Plan (MMCP) ~~or Idaho Medicaid Plus~~ and contact information for participants interested in enrolling in the MMCP ~~or Idaho Medicaid Plus~~. The list also includes website links that provide helpful resources for participants, guardians, family, and person-centered planning team members. In addition, participants receive resources for interviewing potential providers and are encouraged to contact multiple providers to identify a provider that can best meet their needs. The provider list includes a statement that the participant may choose any willing and available provider in the state. Participants are informed that selecting a provider is their choice and that they may choose to change providers at any time. The participant's Plan Developer assists families in selecting service providers at the family's request.

Participants enrolled in the Medicare/Medicaid Coordinated Plan (MMCP) ~~or Idaho Medicaid Plus~~ access Plan Development and Plan Monitoring from Targeted Service Coordinators enrolled in their Health Plan's provider network.

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):

All proposed Individual Support Plans (ISP), Support and Spending Plans (SSP), and addendums/plan changes must be submitted to the Department for review, approval, and prior authorization. No claims for waiver services are paid without prior authorization. The Medicaid Management Information System (MMIS) will not reimburse claims for waivered services without prior authorization in the MMIS.

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:

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.

The Service Plan identifies the Plan Monitor, who is the person or entity responsible for overseeing the implementation of the Service Plan (including effectiveness of back-up plans and access to non-waiver services) and participant health and welfare.

Traditional Model.
The Service Coordinator monitors the implementation of the Individual Service Plan (ISP), including effectiveness of back-up plans and access to non-waiver services and health and welfare of participants who select traditional waiver services. The planning team identifies the frequency of monitoring, which must be at least every ninety (90) days.

Plan monitoring activities include the following:
• Review of the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed;
• Contact with service providers to identify barriers to service provision;
• Discuss with participant satisfaction regarding quality and quantity of services; and
• Review of provider status reviews.

The provider immediately reports all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Department, the Adult Protection Authority, and any other entity identified under IDAPA, or federal law.

Risk factors to the participant as well as, people around the participant, and measures in place to minimize them, including individualized back-up plans and strategies (when needed) must be listed in the approved person-centered Service Plan. Service Coordinators do not have to be available on a twenty-four (24) hour basis but must include an individualized objective on the plan describing what the participant, families, and providers should do in an emergency situation. The individualized objective must include how the Service Coordinator will coordinate needed services after an emergency occurs.

Participants who choose traditional services request adjustments to their ISP during the plan year through the Addendum process. These adjustments must be based on a change to a cost, addition of a service or increase to a service, or a change of provider, addition of a restrictive intervention, or addition of alone time. Additional assessments or information may be clinically necessary. Adjustment of the ISP through an Addendum is subject to prior authorization by the Department. Addendums are required to be submitted fifteen (15) days prior to the requested service start date but should a problem be identified that requires a prompt adjustment to the ISP, participants can request an expedited addendum start date for health and safety reasons. At the request of the participant, if there are documented changes in the participant's condition resulting in a need for additional services that meet medical necessity criteria, the Department will re-evaluate the participant's set budget amount in order to allow a request for these services through the Addendum process.

Self-Directed Model.
The Support Broker monitors the implementation of the Service Plan (including effectiveness of back-up plans and access to non-waiver services) and health and welfare of participants who select consumer-directed waiver services. The participant and circle of supports determine the frequency and methods for monitoring. At a minimum, a Support Broker has face-to-face contact with the participant when providing the following required duties:
• Participating in the annual person-centered planning meeting;
• Assisting the participant to complete the annual re-determination process as needed, including updating the Support and Spending Plan (SSP) and submitting it to the Department
for authorization.

Any other face-to-face contact outside of the Support Broker duties required by rule would be at the discretion of the participant. The Department reviews the proposed SSP. If this plan does not detail sufficient monitoring to protect the participant's health and safety, the Department requires additional detail and appropriate changes to the proposed plan prior to authorization.

The Department investigates all critical incidents and complaints. In addition, the Department conducts ongoing quality assurance outcome reviews and reviews a statistically valid sample of all waiver participants.

Participants who choose consumer-directed services request adjustments to their SSP during the plan year through the Plan Change Process. These adjustments must be based on a change in cost associated with any support category initially

approved on the SSP or adding or subtracting a service in a support category. Adjustment of the SSP through a Plan Change is subject to prior authorization by the Department. Plan changes are required to be submitted fifteen (15) days prior to the requested service start date but should a problem be identified that requires a prompt adjustment to the SSP, participants can request an expedited plan change start date for health and safety reasons. At the request of the participant, if there are documented changes in the participant's condition resulting in a need for additional services that meet medical necessity criteria, the Department will re-evaluate the participant's set budget amount in order to allow a request for these services through the Plan Change process.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percent of service plans that address participants' personal goals. a.
Numerator: Number of service plans that address participants' personal goals. b.
Denominator: Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Services Outcome Review (record reviews and participant interviews)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of service plans that addressed potential and real risks and had back up plan interventions in place. a. Numerator: Number of service plans that addressed potential and real risks and had back up plan interventions in place. b. Denominator: Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Services Outcome Review (record reviews and participant interviews)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of service plans that address participants' needs and health and safety risk factors identified in the individual's assessment(s). a. Numerator: Number of service plans that address participants' needs and health and safety risk factors identified in the individual's assessment(s). b. Denominator: Number of service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Services Outcome Review (record reviews and participant interviews)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

Performance Measure:
Number and percent of service plans that were revised when warranted by changes in participant's needs. a. Numerator: Number of service plans that were revised when warranted by changes in participant's needs. b. Denominator: Number of service plans requiring a revision due to changes in participants' needs that were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Services Outcome Review (record reviews and participant interviews)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of service plans that were updated at least annually. a.
Numerator: Number of service plans that were updated at least annually. b.
Denominator: Number of service plans that were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Services Outcome Review (record reviews and participant interviews)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: 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 % of participant records indicating services were delivered consistent with the service type, scope, amount, duration and frequency in the approved service plan. a. Numerator: Number of records indicating services were delivered consistent with the service type, scope, amount, duration, and frequency in the approved service plan. b. Denominator: Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Services Outcome Review (record reviews and participant interviews)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 that indicated participants were given a choice when selecting waiver service providers. a. Numerator: Number of participant records that indicated participants were given a choice when selecting waiver service providers. b. Denominator: Number of participant records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Services Outcome Review (record reviews and participant interviews)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of participant records that indicated participants were given a choice when selecting waiver services. a. Numerator: Number of participant records that indicated participants were given a choice when selecting waiver services. b. Denominator: Number of participant records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Services Outcome Review (record reviews and participant interviews)

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

The Bureau of Developmental Disability Services uses a variety of strategies to discover/identify problems/issues within the waiver program that are detailed below:

1. The participant eligibility and budget calculation processes are implemented by the Independent Assessment ContractorsProviders, (IACPs). Clinical Supervisors train, monitor and supervise IACPs to ensureinsure eligibility tools and budget calculations are consistently administered. All participant records are maintained in an IACP database which is monitored by the IACP Quality Assurance Specialist. Monthly, Quarterly and Annual IACP reports are submitted by the IACP Quality Assurance Specialist to the Division of Medicaid Contract Monitor. The Contract Monitor reviews the reports to ensureinsure contract compliance with defined benchmarks.

2. BDDS Quality Assurance Specialists conduct biennial Quality Assurance Reviews of all Service Coordination/Plan Monitor providers. The Quality Review ensuresinsures that the provider is meeting the minimum qualifications to conduct the approved Medicaid service. The Department has provided instructional manuals and forms for the plan monitor to utilize in the development of a participant ISP/SSPIndividual Support Plan. Updated processes are also communicated by the Department to these providers using World Wide Web technology. Combined the instructional materials and Quality Assurance Reviews ensuresinsures that plan developers are rendering and submitting consistent and appropriate Individual Support Plans to BDDS for consideration.

During biennial Provider Quality Assurance Reviews, Regional Quality Assurance staff also conducts random participant file reviews in each agency and ensuresinsures that the provider is managing all required processes and procedures correctly. A MMIS Service Utilization report is generated for each reviewed participant and services are compared to provider billing to insure accurate and adequate service provisions are being rendered.

3. Once Individual Support Plans are submitted to BDDS for review and approval, BDDS Care Managers Quality Assurance staff review each ISP individually to ensureinsure participant plans are complete. BDDS Care Managers then review each participant plan to ensureinsure plans adequately meet the needs of the participant and that all healthy and safety considerations have been adequately addressed prior to approval. BDDS Quality Assurance Staff and Care Managers are supervised by BDDS Program Managers. Through supervision and consultation, the BDDS Management Team ensuresinsures plans are consistently and correctly reviewed and that Care Manager actions, (approval, denial, negotiation), are within established guidelines.

The BDDS Managers , BDDS Quality Manager, and the BDDS Operations Manager meet on a weekly basis with the BDDS Bureau Chief to discuss identified inconsistencies and to develop and implement remediation procedures to insure continued consistency throughout the participant plan and service review processes.

b. Methods for Remediation/Fixing Individual Problems

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

The Department reviews and analyzes Service Plans to ensure they address all participants' assessed needs, are developed in accordance with approved policies and procedures, updated/revised at least annually or when warranted by changes in the participant's needs, that services are delivered in accordance with the Service Plan, that participants are afforded choice among services and providers, and that any applicable performance metrics are met. The Department records the results of the review in the appropriate location (e.g., provider review documentation and Quality Improvement System (QIS) report). If any deficiency is identified, the Department notifies the provider of the deficiencies and the actions required to remediate the issue. If the provider fails to remediate the issue, the Department addresses those areas with the provider via the corrective action process. For errors requiring immediate resolution, the Department reaches out to the provider to request a resolution.

The ~~,~~Medicaid Bureau of Developmental Disabilities Services (BDDS) Quality Manager oversees Quality Assurance (QA) remediation and system improvement processes and reporting.
The BDDS Quality Oversight Committee, (comprised of BDDS Bureau Chief, BDDS Quality Manager, BDDS Operations Manager(s), Medicaid Contract Monitors, State Licensing & Certification (L&C) staff, and Medicaid Policy Staff) is responsible for reviewing data and Annual BDDS Level of Care (LOC) Report findings, identifying remediation activities, and monitoring ongoing system improvement initiatives and activities.

The BDDS Management Team identifies and addresses any statewide resource or program issues identified in QA business processes by reviewing and analyzing reports~~-~~. BDDS sends recommended program change or system improvement process requests to the Medicaid Central Office Management Team (COMT) for approval.

Medicaid's COMT reviews BDDS and other Medicaid program report analyses and recommendations, considers Division-wide resources and coordination issues and strategies when making final system-wide change decisions.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

Idaho's Consumer Directed Services option provides a more flexible system, enabling participants to exercise more choice and control over the services they receive helping participants live more productive and participatory lives within their home and communities. This option is provided within the existing system so that it is sustainable and reflects the value of this option for all waiver participants who choose to direct their own services and supports. The process supports participants' preferences and honors their desire to self-direct their own services; how and when supports and services are provided; and who assists them with developing and monitoring a ~~realistic~~ Support and Spending Plan (SSP) that accurately reflects their individual wants and needs.

Once participants are determined eligible for the Developmental Disabilities (DD) waiver, an individualized budget is developed for each participant incorporating a budget methodology which is calculated consistently. The budget model provides participants with an individual budget and a ~~maximum~~ level of funding that varies according to individual needs. This allows for spending flexibility within the set budgeted dollars according to participant's needs and preferences. The support need is determined from the Level of Care (LOC) evaluation completed using a uniform assessment tool. Upon completion of a participant's individual assessment, the individualized budget methodology which the Department uses to determine an individual's budget is ~~reviewed with~~ mailed to the participant either by an Independent Assessment Contractor (IAC) representative or a Medicaid staff.

All Adult DD waiver participants statewide have the option to self-direct their services. Consumer Directed Services allows eligible participants to choose the type and frequency of supports they ~~want,~~want, where they want to receive services, to negotiate the rate of payment, and to ~~hire the~~hire the person or agency they prefer to provide those supports. Through Consumer Directed Services, participants select and hire a qualified ~~trained~~ Support Broker to help plan, access, negotiate, and monitor their chosen services to their satisfaction. The Support Broker provides information and support to assist the participant in:

- making informed choices,
- directing the person-centered planning process, and
- becoming skilled at managing their own supports.

The Support Broker possesses skills and knowledge ~~that go beyond~~ typical gained by completing college courses or community classes or workshops that count toward a degree in the human services field; and have at least two (2) years verifiable experience with the target population and knowledge of services and resources in the development disabilities field. ~~Service Coordination.~~ Support Broker services are included as one of the services ~~one of the Community Support Services~~ that participants ~~may~~ purchase out of their allotted budget dollars. The Support Broker helps participants convene a circle of supports team and engages in a person-centered planning process. The circle of supports team helps the participant plan for and access needed services and supports based on their wants and needs within their established budget.

Participants have the freedom to make choices and plan their own lives, authority to control the resources allocated to them to acquire needed supports, the opportunity to choose their own supports, and the responsibility to make choices and take responsibility for those choices. With the assistance of the Support Broker and legal representative, if one exists, participants are responsible for the following:

- Accepting and honoring the guiding principles of self-direction to the best of their ability,
- Directing the person-centered planning process in order to identify and document support and service needs, wants, and preferences,
- Negotiating payment rates for all paid Community Supports they want to purchase, and
- Developing and implementing employment/service agreements.
- Providing feedback to the best of their ability regarding their satisfaction with the supports they receive and the performance of their workers.

Participants, with the help of their Support Broker, develop a comprehensive SSP based on the information gathered during the person-centered planning meeting. The SSP is reviewed and authorized by the Department and includes participant's preferences and interests by identifying all the supports and services, both paid and non-paid, and the participant's wants and needs to live successfully in their community.

Self-directed Community Supports focus on the participant's wants, needs, and goals in the following areas: (1) personal health and safety, including quality of life preferences, (2) securing and maintaining employment, (3) establishing and maintaining relationships with family, friends, and others to build the participant's natural support community, (4) learning and practicing ways to recognize and minimize interfering behaviors, and (5) learning new skills or improving existing ones to accomplish set goals.

They also identify support needs in the areas of: (1) medical care and medicine, (2) skilled care including therapies or nursing needs, (3) community involvement, ~~community involvement, (~~4) preferred living arrangements including possible roommate(s), and (5) response to emergencies including access to emergency assistance and care.

Participants choose support services, categorized as "Consumer Directed Community Supports," that provide greater flexibility to meet the participant's needs in the following areas:
- My Job Needs. Focuses on assisting an individual in securing and maintaining employment or job advancement, alternate specialized funding and budgeting skills. Under the traditional model, these needs are met through: Supported Employment, Non-Medical Transportation (NMT), Environmental Accessibility Adaptations, and Behavioral Consultation/Crisis Management.
- My Personal Needs. Focuses on identifying supports and services needed to assure the person's health, safety, and basic quality of life. (Under the traditional model, these needs are met through: Residential Habilitation, Chore Services, Skilled Nursing, Home Delivered Meals, Developmental Therapy, Specialized Medical Equipment and Supplies, and Personal Emergency Response Systems (PERS).
- My Relationship Needs. Identifies strategies to assist an individual with establishing and maintaining relationships with immediate family members, friends, their spouse, or other persons and to build their natural support network. Under the traditional model, these needs are met through Residential Habilitation, Environmental Accessibility Adaptations, Respite Care, Chore Services, Adult Day Health, and NMT.
- My Emotional Needs. Addresses strategies to assist an individual with learning and increasingly practicing behaviors consistent with their identified goals and wishes while minimizing interfering behaviors. Under the traditional model, these needs are met through: Residential Habilitation, PERS, and Behavior Consultation/Crisis Management.
- My Learning Needs. Identifies activities that support an individual in acquiring new skills or improving established skills that relate to their identified goals. Under the traditional model, these needs are met through: Residential Habilitation, Environmental Accessibility Adaptations, NMT, Chore Services, PERS, Home Delivered Meals, and Adult Day Health.

With the assistance of their Support Broker, participants hire Community Support Workers or enter into vendor agreements to access needed services and supports in these areas, as identified in their SSP.

Participants selecting Consumer Directed Services are required to choose a qualified Financial Management Services provider, to provide their Financial Management Services and to process and make payments to Community Support Workers for the Community Supports and Services in their SSP. Financial Management Service providers ~~have~~ primarily monitor dollars spent in accordance with the itemized spending plan and ~~for~~ ensur~~c~~ing payment itemization and accuracy. Financial Management Service providers also manage payroll expenses including required tax withholding, unemployment and workers compensation insurance, ensuring completion of criminal history checks or waivers, and providing access of spending reports to the participant and the Support Broker. Financial Management Service providers offer services on behalf of the participant in accordance with Section 3504 of the IRS code and the IRS Revenue Procedure 70-6, which outlines requirements of Financial Management Service providers who are Fiscal Employer Agents.

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

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.

The Department holds regular informational meetings where participants can learn about self-direction. Participants also receive informational materials during their initial and annual eligibility determinations. These materials include a self-assessment tool and information about selecting either traditional waiver services or Consumer-Directed Services. Eligibility notices also include information on traditional waiver and Consumer-Directed Services.

The self-assessment tool provided during the eligibility process helps participants assess potential benefits, risks and responsibilities with selecting Consumer Directed Services. Participants expressing interest in Consumer Directed Services are required to attend a "Guide to a Self-Directed Life" with Department staff. At this meeting, participants receive a Consumer Toolkit that guides them through the self-direction process of selecting a Support Broker, hiring Community Support Workers, and using Financial Management Services.

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:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Skilled Nursing	☒	☒
Transition Services	☒	☒
Specialized Medical Equipment and Supplies	☒	☒
Financial Management Services	☒	☒
Support Broker Services	☒	☒
Community Support Services (Participant Direction)	☒	☒
Non-Medical Transportation	☒	☒

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

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:

Financial Management Services

○ **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:

The Department enters into Provider Agreements with any qualified Financial Management Service provider to offer Financial Management Services to participants selecting Consumer-Directed Services. Entities that furnish Financial Management Services must be qualified to provide such services as indicated in Section 3504 of the Internal Revenue Code.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Participants pay one flat fee payment per member per month paid using their individual budgets.

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:

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:

• Maintains copies of licenses or certification for Community Support Workers as required,
• Maintains employment agreements for each Community Support Worker, and Support Broker,
• Obtains and maintains background check documentation, or documentation of the waived criminal history and background check if applicable, signed by the participant or legal guardian and Support Broker,
• Prepares and distributes a packet of information, including approved forms for agreements, for the participant hiring their own staff, and
• Participates in Department quality assurance activities.

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.

The Department enters into Provider Agreements with qualified providers to perform Financial Management Services for participants selecting Consumer-Directed Services. Financial Management Service provider duties and responsibilities as a Fiscal Employer Agent are outlined in IDAPA 16.03.13.300 through 314.

The Department monitors the activities of each Financial Management Services provider through the following methods:
• Auditing transactions through selection of a random sample of participants. These audits include a review of records and transactions completed on behalf of participants. The audit methodology uses statistically valid standards to assure a random sample and sufficient size to achieve statistical significance.
• Each Financial Management Service provider is required to ensure the quality of their services through internal quality assurance activities. The Department reviews these activities on a regular basis
• Assessment of participant satisfaction with their Financial Management Services provider is obtained as part of regular participant outcome reviews. ~~experience surveys.~~
• Formal assessment of each Financial Management Service provider occurs at least every two (2) years.

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
Chore Services	☐
Environmental Accessibility Adaptations	☐
Home Delivered Meals	☐
Behavior Consultation/Crisis Management	☐
Adult Day Health	☐
Respite	☐
Skilled Nursing	☐
Transition Services	☐
Residential Habilitation	☐
Personal Emergency Response System	☐
Specialized Medical Equipment and Supplies	☐
Financial Management Services	☐
Support Broker Services	☒
Community Support Services (Participant Direction)	☐
Supported Employment	☐
Non-Medical Transportation	☐

☐ **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:

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:

The Department assists participants and legal guardians with this transition and assures that authorization for services under Consumer-Directed Services do not expire until new services are in place. The Division of Medicaid provides technical assistance and guidance as requested by participants, Support Brokers, and circles of support.

Transition from Consumer-Directed Services to traditional waiver services will not take more than 120 days and in most cases will be accomplished in 60 to 90 days. This transition time is spent redetermining the Level of Care (LOC) needs, development of a new plan, and review and authorization of the new plan. The participant remains with Consumer-Directed Services until this process is completed so that there is no interruption in services.

If at any time there are health and safety issues, the Care Manager works closely with the participant to ensure the participant's health and safety is protected. This may include authorizing additional CSW ~~Community Crisis Supports~~ hours to address any immediate crise~~i~~is and/or authorizing an expedited traditional ISP ~~emergency 120-day Transition Plan~~ to assure a smooth transition from Consumer-Directed waiver services to traditional waiver services.

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.

Participants must meet the following requirements, or the Department may require the participant to discontinue Consumer-Directed Services.

1. Required Supports. The participant is willing to work with a Support Broker and a Financial Services Provider (Fiscal Employer Agent).
2. Support and Spending Plan (SSP). The participant follows their SSP.
3. Risk and Safety Back-Up Plans. The participant follows their identified back-up plans to manage risks and ensure safety.
4. Health and Safety Choices. The participant's choices do not directly endanger their health, welfare and safety, or endanger or harm others.

If the Department discontinues Consumer-Directed Services, the participant receives a notice of decision from the Department that includes the decision to involuntarily discontinue participant direction of services, the Department's reason(s) for the decision, an explanation of the transition process to traditional waiver services, and an explanation of the participant's appeal rights with instructions on how and when to request a Fair Hearing.

The Department ensures the continuity of services during the involuntary transition to traditional waiver services by coordinating with the participant and the Plan Developer to develop an initial ISP, expedited as necessary, ~~120-day Transition Plan~~ meeting the immediate health and safety needs of the participant. ~~This Transition Plan provides necessary services to the participant during the transition period to allow sufficient time to calculate a traditional budget and develop~~ a traditional Service Plan.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only			Budget Authority Only or Budget Authority in Combination with Employer Authority		
Waiver Year	Number of Participants			Number of Participants		
Year 1					1819	
Year 2					2195	
Year 3					2535	
Year 4					2971	
Year 5					3435	

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:

☒ **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:

The participant and Community Support Worker determines who assumes the above costs.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Method to conduct background checks does not vary from Appendix C-2-a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

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

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.

A calculation tool establishes a budget based on information entered on an Inventory of Individual Needs, an assessment tool designed to capture the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to their developmental disability. The tool is based on a regression analysis model which calculates a budget that correlates with each participant's individualized needs.

The budget tool is periodically evaluated and adjusted ensuring participant budgets are calculated using information that produces the greatest statistical validity when analyzing a participant's need and cost of services.

To ensure a participant's budget adequately meets their individual needs, Idaho provides the following safeguards:

1) When the participant receives notice regarding their budget amount, they can appeal that budget within twenty-eight (28) days of the date on the eligibility notice. The Department reviews all appeals received to ensure all participant needs were accurately captured through responses on the inventory of individual needs, and the participant does not have additional needs that meet medical necessity criteria. If there are medically necessary services needed to ensure a participant's health and safety, but the need for such services is not addressed by the inventory, dollars to meet those needs are added to the budget. Individualized budgets are re-evaluated annually.

2) At the request of the participant, the Department re-evaluates the set budget amount when there are documented changes in the participant's condition resulting in a need for services meeting medical necessity criteria to ensure a participant's health and safety, and not reflected on the current inventory of individual needs. When the Department determines that a documented change in condition is not reflected on the current inventory, a new inventory is completed, and budget calculated for the participant. The participant has the right to appeal this new budget.

Budget setting methodology is available to anyone submitting a Public Record Request.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

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.

Participant selecting Consumer-Directed Services receive a written notice of decision from the Department that includes the decision to approve or deny eligibility. When eligibility is approved, the notice includes the participant's assigned budget amount. When eligibility is denied, the notice includes the Department's reason(s) for denial.

For all decisions, the notice includes an explanation of the participant's appeal rights with instructions on how and when to request a Fair Hearing.

As outlined in Appendix C-4, a participant who believes their assigned budget is not adequate to meet their assessed needs may appeal by requesting a Fair Hearing within twenty-eight (28) days of the date on the notice.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

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

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:

To ensure appropriate utilization of a participant's budget (including 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 under-utilization), Idaho provides the following safeguards:

1. Budgeted amounts are planned in relation to the participant's needed supports. Community Support Worker employment agreements submitted to the Fiscal Employer Agent (FEA) identifies the negotiated rates agreed upon with each Community Support Worker along with the specific support being purchased, the frequency and duration that the support will be provided, and the payment unit (hourly or daily). The FEA compares and matches the employment agreements to the appropriate support categories identified on the initial and annual spending plan prior to processing timesheets or invoices for payment.

2. The Department authorizes all budgets and Support and Spending Plans (SSP). Any changes to approved budget dollars allocated within a support ~~categorycategory~~, or the type of support used must be reviewed and authorized by the Department.

3. The participant's Support Broker assists the participant to monitor and review their budget.

4. The FEA provides a secure file transfer protocol (SFTP) site for the Department, participants, and their employees to access participant information such as timecards and account statements. On a monthly basis (or upon participant's request), the FEA generates an Account Summary Statement for each participant and makes this statement available on a secure website or in hard copy. The Account Summary Statement provides an overview of each participant's account, including the services accessed and the remaining dollar amount in their budget. ~~Additionally, Additionally, the Fiscal Employer Agent notifies the Department of potential budget over-utilization by a participant.~~

When potential budget utilization issues arise, the Support Broker works with the participant and the Department to adjust utilization or address service delivery problems, and/or request budget modifications when necessary to protect the health and welfare of the participant.

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.

Participants may appeal any Department decision related to waiver eligibility or waiver services. Appeal rights are included on ~~all~~ the following notices:

• Participants who do not meet Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Level of Care criteria;
• Eligibility approval notices that include the participant's individualized budgets;
• Participants who are not provided the choice of a Home and Community Based Settings (HCBS) as an alternative to institutional care;
• Participants whose services on their Individual Support Plan (ISP) or Support and Spending Plan (SSP) are denied, reduced, terminated, or suspended;
• Participants who are denied the provider of their choice;

The Department sends notices to the participant and guardian in writing ~~and~~ containing information on how to appeal Department decisions that negatively affect eligibility or services. Copies of these notices are maintained in the participant's file. In order to appeal a decision, a participant must request a Fair Hearing within twenty-eight (28) days from the date the notice was mailed.

When a participant requests a Fair Hearing, the Department extends services for annual plan or temporarily authorized services under appeal until a ~~settlement~~ resolution between the Department and the participant is reached or the participant's administrative appeal rights are fully exhausted. The Department completes an internal review of the participant's file. If this review uncovers additional information or determines that a specific need was inaccurately assessed or missed, Medicaid staff work with the participant to resolve the appeal prior to a Fair Hearing. If a settlement is not jointly agreed upon by the participant and the Department, a Fair Hearing is scheduled.

Participants and the public may learn more about the Department's Fair Hearing processes and policies by accessing the Department of Health & Welfare's Appeals and Fair Hearings website at https://healthandwelfare.idaho.gov/appeals-and-fair-hearings. This website provides a detailed description of the Department's Fair Hearing process as well as contact information for additional questions.

In addition, participants may receive information on Fair Hearings from the Consumer Toolkit, distributed by the Independent Assessment Contractor (IAC), which describes the participant's right to appeal any Department decision that negatively affects their eligibility or services.

In the Fair Hearing process, a Hearing Officer acts as an impartial third party in reviewing the Department's actions. The Department and the participant each present their case before the Hearing Officer. The Hearing Officer considers testimony and evidence presented during hearing along with the pertinent state rules and federal regulations when making a decision.

A written decision is issued by the Hearing Officer and sent to the Department and the participant.

When all administrative remedies are exhausted, the participant may appeal the final decision by requesting a judicial review by the District Court.

~~Details regarding the appeal process are provided in IDAPA 16.05.03 "Contested Case Proceedings and Declaratory Rulings."~~

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:

Department of Health and Welfare

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).

Upon receipt of a complaint/critical incident, the Department:
1. Determines if it meets the definition of a complaint/critical incident to be tracked in the complaint/incident reporting application.
2. Informs participants that they may exercise their choice of waiver providers at any time and that filing a grievance or complaint is not a pre-requisite or substitute for a Fair Hearing.
3. Enters the details of the complaint/critical Incident in the SharePoint Complaint/Incident Reporting Application. Including the date of the complaint, nature of the complaint, classification, and identifying information.
~~4. Conducts a search in the reporting application for existing complaints regarding the same provider/participant and includes this information in the narrative.~~
~~5.~~4. Records the details of the investigation, dates and persons interviewed, and referrals to appropriate resources that were made. Complaints and critical incidents are resolved through thorough investigation which may include referral and collaboration with Adult Protection, Law Enforcement, the Medicaid Program Integrity Unit, and other entities. Additionally, investigations may result in provider corrective action and/or appropriate sanction which may include revocation of provider agreement.
~~6.~~5. Records the response resolution date, closure date and outcome.

The following are the definition of complaints that are expected by the Medicaid Administrator to be tracked through the Complaint/Incident Reporting application.

COMPLAINTS
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 & Privacy.
1) 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;
2) Confidentiality - not talking about or disclosing personal information regarding a participant of the Department.

Contract Services - Issues involving an entity providing services under a contract with the Department (Does not include providers of services under Medicaid Provider Agreements).

~~Developmental Disabilities Agency (DDA) Certification Compliance – Licensing and Certification (L&C) Field Only~~

Denial of Service/Eligibility - The denial by the Department to provide or reimburse for a service or program requested by a client or their representative. Appeal rights must always
be discussed with the participant in a denial investigation.

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).

Fraud - An intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to themself or some other person.

Referrals - Issue or complaint/critical incident dealing with the ability of a provider or participant to obtain a referral to a provider other than the assigned Healthy Connections Primary Care Provider.

Self-Direction Budget Amount - Issues that are related to the budget setting process for Self-Direction services under this waiver.

Quality of Care - Issues that involve the meeting or not meeting of rules, policies, or commonly accepted practice standards around care/services provided to clients of the Department.

Violation of Rights - An intentional or unintentional infringement or transgression against an individual's rights.

(Critical Incident)

Other - When the complaint does not fit one of the classifications listed, this classification may be

used and must

describe the complaint/critical incident.

State laws, regulations, and policies related to this topic include:
- IDAHO CODE TITLE 39 – Health and Safety
- HEALTH AND SAFETY CHAPTER 53 - ADULT ABUSE, NEGLECT AND EXPLOITATION ACT

Definitions:
39-5302. (1)(t1)" Physical aAbuse" means the intentional or negligent infliction of physical pain, injury, or unjust chemical or physical restraint on a vulnerable adult or death injury or mental injury.
39-5302 (1)(x) "Psychological abuse" means the infliction of fear, anguish, agitation, or other emotional distress through verbal or nonverbal acts through unjust confinement of a vulnerable adult.
39-3502 (1)(z) "Sexual abuse" means touching, fondling, intercourse, or any other sexual activity with a vulnerable adult when the vulnerable adult is unable to understand, unwilling to consent, threatened, or physically forced.
39-5302.(1)(r) (7)"Neglect" means failure of a caretaker to provide food, clothing, shelter or medical care the absence of which impairs or threatens reasonably necessary to sustainable the life orand health of a vulnerable adult, or the failure of a vulnerable adult to provide those services for themself.
39-5302. (1)(jr6) "Financial eExploitation" means the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds, of a vulnerable adult by any person or entity for profit of advantage other than for the vulnerable adult's profit of advantage. means an action that may include, but is not limited to, the unjust or improper use of a vulnerable adult's financial power of attorney, funds, property, or resources by another person for profit or advantage.
35-5302 (1)(ee) "Vulnerable adult maltreatment" or "maltreatment" means the intentional or negligent infliction of pain or injury on a vulnerable adult, including financial exploitation, human trafficking, neglect, physical abuse, psychological abuse, or sexual abuse.
39-5303.Duty to Report Cases of Vulnerable Adult MaltreatmentAbuse, Neglect or Exploitation of Vulnerable Adults.

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).

Incidents of Abuse Neglect or Exploitation:

Idaho Statute defines abuse, neglect and exploitation as follows:
• Abuse - The intentional or negligent infliction of physical pain, injury or mental injury. Idaho Code 39-5302(1)
• Neglect - Failure of a caretaker to provide food, clothing, shelter, or medical care, the absence of which impairs or threatens ~~reasonably necessary to~~ sustainable life or~~and~~ health of a vulnerable adult ~~or child, or the failure of a vulnerable adult to provide those services to themself~~. Idaho Code 39-5302(~~7~~1)(r)
• Financial Exploitation ~~- An action which may include, but is not limited to, the misuse of a vulnerable person's funds, property, or resources by another person for profit or advantage.~~ Idaho Code, 39-5302(~~6~~1)(j)

Idaho's "Adult Abuse, Neglect and Exploitation Act" requires that ~~any of the following~~certain individuals with reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, or exploited immediately reports such information to the Idaho Commission on Aging.~~:~~
~~physician,~~
~~nurse,~~
~~employee of a public or private health facility,~~
~~Employee of a state licensed or certified Residential Facility serving vulnerable adults,~~
~~medical examiner,~~
~~dentist,~~
~~ombudsman for the elderly,~~
~~osteopath,~~
~~optometrist,~~
~~chiropractor,~~
~~podiatrist,~~
~~social worker,~~
~~police officer,~~
~~pharmacist,~~
~~physical therapist, or~~
~~home care worker.~~

In addition, when there is reasonable cause to believe that abuse or sexual assault has resulted in death or serious physical injury jeopardizing the life, health, or safety of a vulnerable adult, any person required to report shall also report such information ~~within four (4) hours~~ to the appropriate law enforcement agency. (Section 39-5303, Idaho Code).
The Department also requires that individuals responsible for monitoring a participant's plan must immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Division of Medicaid, the Adult Protection Authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law.

Reports to Medicaid may be made by phone, mail, fax, email, or in person. The Department tracks reports and ensures that each complaint or critical incident includes the following information: documentation of incident/complaint, assigned Department Staff, contact information, investigation information, and resolution.
~~In addition to reporting abuse, neglect and exploitation, the Department requires Residential Habilitation providers to report all incidents and allegations of mistreatment and injuries of unknown origin to the administrator and to Adult Protection and law enforcement officials within four (4) hours, as required by law under Section 39-5303, Idaho Code.~~

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.

At the time of initial eligibility determination (and each annual reassessment), all participants receive information on participant rights and information concerning protections from abuse, neglect, and exploitation, and 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. It also includes contact information for the Department and advocacy organizations if they have questions about their rights or want to file a complaint related to a violation of rights. The Independent Assessment Contractor (IAC) reviews this information with the participant and other individuals who are at the appointment.

In addition, providers are required to develop, implement, and inform participants of written policies to protect and promote the rights of each participant including the right to file complaints and the right to due process.

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.

Investigators with the Idaho Commission on Aging:
• Determine the nature, extent and cause of the abuse, neglect, or exploitation,
• Examine the evidence and consult with persons thought to have knowledge of the circumstances,
• Identify, if possible, the person alleged to be responsible for the abuse, neglect or exploitation of the vulnerable adult, and
• Determine if the allegation is either substantiated or unsubstantiated.

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 Adult Protection 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 the 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 their legal representative.

The Adult Protection worker closes 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 Adult Protection worker determines that the vulnerable adult has unmet service needs, they initiate appropriate referrals for supportive services with consent of the vulnerable adult or their legal representative.

Reports that come to the Department directly regarding abuse, neglect, or exploitation are referred to the local Adult Protection Agency for further investigation. Complaints not related to abuse, neglect or exploitation are referred to Medicaid. Reports that cannot be immediately resolved by the initial point of contact are assigned a priority level depending on the nature of the report.
1. Priority one (1) indicates that there is an immediate health or safety issue. These reports must be immediately addressed and are typically reported to the Adult Protection Authority and/or law enforcement.
2. Priority two (2) indicates that there is not an immediate health or safety issue. These reports are acted on within ten (10) business days.
3. Priority three (3) indicates that another timeframe requirement outlined in rule or law. In these cases, follow-up is completed within the timeframe outlined in rule or law.
Upon resolving a complaint, the assigned Department staff completes all documentation and notifies appropriate persons. When corrective actions are required, Medicaid Administration notifies Facility Standards, the Medicaid Program Integrity Unit, and/or the Deputy Attorney General as needed. Statewide compliance with the Department's complaint process and priority timelines are assessed at least quarterly.

The Department ensures that staff adheres to response timelines based on priority level as described in Appendix G-1.b. Review of statewide compliance with priority timelines is assessed at least quarterly during the Bureau of Developmental Disabilities Services (BDDS) Leadership Team meetings. The Bureau Leadership Team consists of the Bureau Chief and the Regional Program Managers. Complaints and critical incidents are processed in a timely manner, and all written communication are reviewed by a program supervisor or designee(s) prior to mailing the results to the submitter.

A complaint or critical incident always requires a documented response to the person submitting the complaint/critical incident. The mode and content of the reply depends on the nature or complexity of the complaint/critical incident. The ~~resolution or~~ status of the investigation must be communicated to the submitter within ten (10) business days of completing an investigation.

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 Idaho Commission on Aging investigates all allegations of abuse, neglect, and exploitation. The Commission contracts with an Area Agency on Aging to complete investigations and is responsible to provide ongoing oversight of these contracts.

The Idaho Commission on Aging meets quarterly with Medicaid and shares information regarding open/ongoing critical incident cases and events. 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 meets immediately to staff a case.

The Department of Health and Welfare is responsible for all other aspects of critical incidents that affect waiver participants. The status and resolution of each report is available in the Complaint/Critical Incident database. Oversight of the Complaint/Critical Incident Process is conducted through a quarterly review by the Bureau of Developmental Disabilities Services (BDDS) Program Managers and Bureau Chief during BDDS Leadership Team Meetings.

The Department requires that providers and other individuals responsible for monitoring the approved plan of service immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the Agency Administrator, the Department, or any other entity identified under Idaho Code, or federal law.
Critical Incident Data is collected using the "Complaint and Critical Incident Database" SharePoint. Staff record information about each Critical Incident to include the following:
- Who the Critical Incident was received by,
- Date Critical Incident Received,
- Expected date of Critical Incident Investigation resolution,
- Program Responsible for Investigating the Critical Incident,
- How the Critical Incident is specifically related to Developmental Disability Services to include DD Waiver provider type/specialty,
- Staff assigned to conduct the Critical Incident Investigation,
- State Region/geographic locale where Critical Incident Occurred,
- Source of the Critical Incident, (who reported the incident to the Department),
- Nature of the Critical Incident, (abuse, neglect, exploitation, serious injury, etc.),
- Description of the Critical Incident,
- Specific information regarding participant of concern, agency or provider involved, and identifying information regarding the person who submitted the Critical Incident to the Department,
- Participant Guardian identifying information, if applicable,
- Department Action Taken as a result of the investigation and outcome,
- Whether the critical incident was substantiated or not substantiated,
- Whether Adult Protection and/or Law Enforcement was contacted, and
- Date Critical Incident was closed.

On a quarterly basis, the BDDS ~~Quality Manager~~Business Analyst uploads the SharePoint Critical Incident data to a Spreadsheet for analysis in order to identify trends and patterns and to recommend quality improvement strategies to address identified issues and trends. ~~Each January, an annual Complaint and Critical Incident Report is compiled and published by the Quality Manager for the previous year documenting annual trends and patterns and recommending quality improvement strategies to address identified issues and trends.~~These recommendations are reviewed by the BDDS Program Managers, Business Analyst and Bureau Chief during BDDS Leadership team meetings.

Additional Oversight for Participants Enrolled in a Dual Plan.
The Bureau of Long Term Care (BLTC) monitors critical incidents and events for all waiver participants enrolled in the Medicare Medicaid Coordinated Plan (MMCP) ~~or Idaho Medicaid Plus~~. BLTC requires that the Health Plans maintain a Complaint and Critical Incident Resolution and Tracking System for all Complaints and Critical Incidents which includes safeguards to prevent abuse, neglect and exploitation. These requirements are included in the Managed Care contracts with the state. When BLTC receives information about a critical incident or event regarding a participant on this waiver, complaints are communicated to BDDS immediately. Resolutions for these participants are managed under this waiver as well as under the Managed Care BLTC Contract Monitoring process.

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 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).

1. Person-Centered Planning Process. The use of restraints must be determined, agreed to, and documented through the person-centered planning process.

2. Positive Intervention Prior to Use.
• Positive behavior interventions must be used prior to, and (if applicable) in conjunction with, the implementation of any restraint.
• Restraints (other than physical restraint in an emergency) may only be used when the provider documents that the restraints represent the least-restrictive environment for the participant to live safely and effectively in the community.

3. Written Behavior Change Plan.
• Restraints may be used only when a written behavior change plan is developed by the participant, the participant's decision-making authority (if applicable), the participant's Service Coordinator/Support Broker, and the participant's person-centered planning team; and the plan is authorized prior to implementation by the appropriate authority (as specified below).
• The written behavior change plan must:
- Describe how positive behavior interventions will be used prior to, and (if applicable) in conjunction with, the implementation of any restraint;
- Describe how the restraint will be used;
- Document that the restraint represents the least-restrictive intervention necessary for the participant to live safely and effectively in the community; and
- Document the appropriate authority (as specified below) has reviewed and approved the use of the restraint.

4. Informed Consent. Written informed consent is required for all use of restraints.

5. Appropriate Circumstances and Authorizations.
• Chemical restraints may be used only when authorized by a practitioner of the healing arts. ~~n attending physician~~.
• Mechanical restraints may be used for medical purposes only when authorized by a practitioner of healing arts ~~n attending physician~~.
• Mechanical restraints may be used for non-medical purposes only when recommended ~~authorized~~ by a Qualified Intellectual Disabilities Professional (QIDP) or a Behavior Consultant/Crisis Management ~~provider.~~provider and prior-approved by a practitioner of healing arts.
Physical restraints may be used for non-emergency situations only when authorized by a QIDP or a Behavior Consultant/Crisis Management provider~~.~~and prior-approved by a practitioner of healing arts.
• Physical restraint may be used, without a written and approved behavior change plan, in an isolated emergency to prevent injury to the participant or others, but the emergency use must be documented in the participant's record.
• Seclusion may be used only when ~~authorized~~ recommended by a QIDP or a Behavior Consultant/Crisis Management Consultant~~.~~and written into the Behavior Change Plan.

6. Personnel Training.
• Personnel involved in the administration of restraints must be trained to meet any health, behavioral, or medical requirements of the participants they serve.
• Personnel involved with supervision and oversight of restraints must, at a minimum, meet the provider qualifications of QIDP.

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:

1. Plan Approval by Department.
The Department reviews all plans of service prior to implementation. The Department assures that the safeguards specified above have been met prior to plan authorization. If all of the above safeguards have not been met, the proposed plan of services is not authorized.

2. Monitoring and Detection by Department.
The Department's methods for monitoring and detecting the unauthorized use of restraints include the review and analysis of complaints and critical incidents, participant service outcomes, and provider Quality Assurance (QA).

- Complaints and Critical Incidents Reviews:
  - o The Department receives complaints and critical incident reports from participants and providers on a continuous and ongoing basis.
  - o All complaints and critical incidents are recorded in a designated database, and each record contains the specific dates of the incident, nature of complaint/critical incident, narrative, and action taken by the Department.
  - o The Department reviews all complaints and critical incidents received regarding inappropriate use of restraints. When potential inappropriate use of restraints is discovered, the Department conducts an enhanced review to substantiate the claim.
  - o The number of complaints received and substantiated is tracked on a quarterly basis in the Department's QA database.
  - o If providers are discovered using restraints without approval, they are referred to the applicable authority and have appropriate action taken against their certification and/or Medicaid provider agreement.
  - o Depending on the seriousness of the violation and the provider's history, action may range from a required plan of correction to termination of provider agreement and/or Medicaid certification.
- Participant Service Outcome Reviews.
  - o The Department conducts Adult Service Outcome Reviews (ASOR) on an annual basis to ensure positive outcomes, quality of care, and the overall health and safety of waiver participants.
  - o The ASOR includes both a file review and a participant interview/.
  - o Results of the ASOR are tracked on a quarterly basis in the Department's QA database.
  - o When potential inappropriate use of restraints is discovered, the Department conducts an enhanced review to substantiate the claim.
  - o If providers are discovered using restraints without approval, they are referred to the applicable authority and have appropriate action taken against their certification and/or Medicaid provider agreement.
  - o Depending on the seriousness of the violation and the provider's history, action may range from a required plan of correction to termination of provider agreement and/or Medicaid certification.
- Provider Quality Assurance Reviews.
  - o The Department conducts provider QA reviews to ensure providers meet designated quality standards.
  - o Provider agencies are reviewed within six (6) months of first providing services to participants, and any provider agencies that have any active billing of waiver services will be reviewed on a two (2) year cycle. Provider QA Reviews may need to be conducted more often in some circumstances due to the type and amount of corrective action plans the agency has on the final report of each review.
  - o Results of the provider QA review are tracked on a quarterly basis in the Department's QA database.
  - o When potential inappropriate use of restraints is discovered, the Department conducts an enhanced review to substantiate the claim.
  - o If providers are discovered using restraints without approval, they are referred to the applicable authority and have appropriate action taken against their certification and/or Medicaid provider agreement.
  - o Depending on the seriousness of the violation and the provider's history, action may range from a required plan of correction to termination of provider agreement

and/or Medicaid certification.

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.

1. Person-Centered Planning Process.
• The use of restrictive interventions must be determined, agreed to, and documented through the person-centered planning process.
• If the Home and Community Based Setting (HCBS) 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 includes 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:
o Freedom to control personal resources,
o Freedom to work in competitive integrated settings,
o Freedom to engage in community life,
o Freedom to receive services in the community,
o Right to privacy,
o Autonomy in making choices, including daily activities, physical environment, and with whom to interact, and
o Opportunities for choice regarding services and supports.
• Setting qualities that may warrant an exception include:
o Lockable bedroom or living unit doors,
o Choice of roommate,
o Freedom to furnish and decorate living space(s),
o Freedom and support to control schedules and activities,
o Access to food,
o Ability to have visitors at any time, and
o Physically accessible setting

2. Positive or Non-Aversive- Intervention Prior to Use.
• Positive behavior or Non-Aversive interventions must be used prior to, and (if applicable) in conjunction with, the implementation of any restrictive intervention.
• Restrictive interventions may only be used when the provider documents that the restrictive intervention is the least-restrictive intervention for the participant to live safely and effectively in the community.

3. ~~Written Behavior Change Plan.~~ Adult Developmental Disability Services Restraint/Restrictive Intervention Review Request (RIR) Form.
• Restrictive Interventions may be used only when a ~~written behavior change plan~~ RIR form is developed by the participant, the participant's decision-making authority (if applicable), the participant's Service Coordinator/Support Broker, and the participant's person-centered planning team; and the plan is authorized prior to implementation by the appropriate authority (as specified below).
• The ~~written behavior change~~RIR form plan must:
o Describe how positive behavior interventions will be used prior to, and (if applicable) in conjunction with, the implementation of any restrictive interventions;
o Describe how the restrictive intervention will be used;
o Document the restrictive intervention is the least-restrictive intervention necessary for the participant to live safely and effectively in the community; and
o Document the appropriate authority (as specified below) has reviewed and approved the use of the restrictive intervention.

4. Informed Consent. Written informed consent is required for all use of restrictive interventions.

5. Appropriate Circumstances and Authorization.
• Restraints may only be used as specified in Appendix G-2-a above; and
• Seclusion may only be used as specified in Appendix G-2-c below.

6. Personnel Training.
   - Personnel involved in the administration of restrictive interventions must be trained to meet any health, behavioral or medical requirements of the participants they serve.
   - Personnel involved with supervision and oversight of restrictive interventions must, at a minimum meet the provider qualifications of Qualified Intellectual Disabilities Professional (QIDP).

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:

1. Plan Approval by Department. The Department reviews all plans of service prior to their implementation and assures that the safeguards specified above have been met prior to plan authorization. If all of the above safeguards have not been met, the proposed plan of services is not authorized.

2. Monitoring and Detection by Department. The Department's methods for monitoring and detecting the unauthorized use of restrictive interventions include the review and analysis of complaints and critical incidents, participant service outcomes, and provider Quality Assurance (QA).

- Complaints and Critical Incidents Reviews.
  - o The Department receives complaints and critical incident reports from participants and providers on a continuous and ongoing basis.
  - o All complaints and critical incidents are recorded in a designated database, and each record contains the specific dates of the incident, nature of complaint/critical incident, narrative, and action taken by the Department.
  - o The Department reviews all complaints and critical incidents received regarding violations of participant rights, including inappropriate use of restrictive interventions. When potential inappropriate use of restrictive interventions is discovered, the Department conducts an enhanced review to substantiate the claim.
  - o The number of complaints received and substantiated is tracked on a quarterly basis in the Department's QA database.
  - o If providers are discovered using restrictive interventions without approval, they are referred to the applicable authority and have appropriate action taken against their certification and/or Medicaid Provider Agreement.
  - o Depending on the seriousness of the violation and the provider's history, action may range from a required plan of correction to termination of Provider Agreement and/or Medicaid certification.
- Participant Service Outcome Reviews.
  - o The Department conducts Adult Service Outcome Reviews (ASOR) on an annual basis to ensure positive outcomes, quality of care, and the overall health and safety of waiver participants.
  - o The ASOR includes both a file review and a participant interview.
  - o Results of the ASOR are tracked on a quarterly basis in the Department's QA database.
  - o When potential inappropriate use of restrictive interventions is discovered, the Department conducts an enhanced review to substantiate the claim.
  - o If providers are discovered using restrictive interventions without approval, they are referred to the applicable authority and have appropriate action taken against their certification and/or Medicaid provider agreement.
  - o Depending on the seriousness of the violation and the provider's history, action may range from a required plan of correction to termination of provider agreement and/or Medicaid certification.
- Provider Quality Assurance Reviews.
  - o The Department conducts provider QA reviews to ensure providers meet designated quality standards.
  - o Provider agencies are reviewed within six (6) months of first providing services to participants, and any provider agencies that have any active billing of waiver services will be reviewed on a two (2) year cycle or three (3) year cycle. Provider QA Reviews may need to be conducted more often in some circumstances due to the type and amount of corrective action plans the agency has on the final report of each review.
  - o Results of the provider QA review are tracked on a quarterly basis in the Department's QA database.
  - o When potential inappropriate use of restrictive interventions is discovered, the Department conducts an enhanced review to substantiate the claim.
  - o If providers are discovered using restrictive interventions without approval, they are referred to the applicable authority and have appropriate action taken against their certification and/or Medicaid provider agreement.
  - o Depending on the seriousness of the violation and the provider's history, action may range from a required plan of correction to termination of provider agreement and/or Medicaid certification.

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 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).

1. Person-Centered Planning Process. The use of seclusion must be determined, agreed to, and documented through the person-centered planning process.

2. Positive Intervention Prior to Use.
• Positive behavior interventions must be used prior to, and (if applicable) in conjunction with, the implementation of seclusion.
• Seclusion may only be used when the provider documents that the seclusion represents the least-restrictive environment for the participant to live safely and effectively in the community.

3. ~~Written Behavior Change Plan.~~ Adult Developmental Disability Services Restraint/Restrictive Intervention Review Request (RIR) Form.
• Seclusion may be used only when a ~~written behavior change plan~~ RIR form is developed by the participant, the participant's decision-making authority (if applicable), the participant's Service Coordinator/Support Broker, and the participant's person-centered planning team; and the plan is authorized prior to implementation by the appropriate authority (as specified below).
• The written behavior change plan must:
- Describe how positive behavior interventions will be used prior to, and (if applicable) in conjunction with, the implementation of seclusion;
- Describe how seclusion will be used;
- Document the seclusion is the least-restrictive intervention necessary for the participant to live safely and effectively in the community; and
- Document the appropriate authority (as specified below) has reviewed and approved the use of seclusion.

4. Informed Consent. Written informed consent is required for all use of seclusion.

5. Appropriate Circumstances and Authorization.
• Seclusion may be used only when authorized by a Qualified Intellectual Disabilities Professional (QIDP) or a Behavior Consultant/Crisis Management Consultant.

6. Personnel Training.
• Personnel involved in the administration of seclusion must be trained to meet any health, behavioral or medical requirements of the participants they serve.
• Personnel involved with supervision and oversight of seclusion must, at a minimum meet the provider qualifications of QIDP.

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:

1. Plan Approval by Department. The Department reviews all plans of service prior to their implementation and assures that the safeguards specified above have been met prior to plan authorization. If all the above safeguards have not been met, the proposed plan of services is not authorized.

2. Monitoring, Detection and Remediation by Department. The Department's methods for monitoring and detecting the unauthorized use of seclusion include the review and analysis of complaints and critical incidents, participant service outcomes, and provider Quality Assurance (QA).

• Complaints and Critical Incidents Reviews:

- The Department receives complaints and critical incident reports from participants and providers on a continuous and ongoing basis.
- All complaints and critical incidents are recorded in a designated database, and each record contains the specific dates of the incident, nature of complaint/critical incident, narrative, and action taken by the Department.
- The Department reviews all complaints and critical incidents received regarding inappropriate use of seclusion. When potential inappropriate use of restraints is discovered, the Department conducts an enhanced review to substantiate the claim.
- The number of complaints received and substantiated is tracked on a quarterly basis in the Department's QA database.
- If providers are discovered using seclusion without approval, they are referred to the applicable authority and have appropriate action taken against their certification and/or Medicaid Provider Agreement.
- Depending on the seriousness of the violation and the provider's history, action may range from a required plan of correction to termination of Provider Agreement and/or Medicaid certification.

• Participant Service Outcome Reviews.

- The Department conducts Adult Service Outcome Reviews (ASOR) on an annual basis to ensure positive outcomes, quality of care, and the overall health and safety of waiver participants.
- The ASOR includes both a file review and a participant interview/survey.
- Results of the ASOR are tracked on a quarterly basis in the Department's QA database.
- When potential inappropriate use of seclusion is discovered, the Department conducts an enhanced review to substantiate the claim.
- If providers are discovered using seclusion without approval, they are referred to the applicable authority and have appropriate action taken against their certification and/or Medicaid Provider Agreement.
- Depending on the seriousness of the violation and the provider's history, action may range from a required plan of correction to termination of Provider Agreement and/or Medicaid certification.

• Provider Quality Assurance Reviews.

- The Department conducts provider QA reviews to ensure providers meet designated quality standards.
- Provider agencies are reviewed within six (6) months of first providing services to participants, and any provider agencies that have any active billing of waiver services will be reviewed on a two (2) year cycle or three (3) year cycle. Provider QA Reviews may need to be conducted more often in some circumstances due to the type and amount of corrective action plans the agency has on the final report of each review.
- Results of the provider QA review are tracked on a quarterly basis in the Department's QA database.
- When potential inappropriate use of seclusion is discovered, the Department conducts an enhanced review to substantiate the claim.
- If providers are discovered using seclusion without approval, they are referred to the applicable authority and have appropriate action taken against their certification and/or Medicaid Provider Agreement.
- Depending on the seriousness of the violation and the provider's history, action may range from a required plan of correction to termination of Provider Agreement and/or Medicaid certification.

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.

Prior to receiving initial waiver services, and at least annually thereafter, participants must be assessed by their Primary Care Physician on their ability to self-administer medications. Participants who are not capable of self-administration of medications must have their medications administered by an individual licensed in Idaho to administer medications.

Participants who are determined by their physician to be able to self-administer their medications must be further assessed to determine whether they require assistance to administer their own medications. This assessment must be completed by a licensed nurse or other qualified professional and must document that the participant:
1. Understands the purpose of the medication.
2. Knows the appropriate dosage and times to take the medication.
3. Understands the expected effects, adverse reactions or side effects, and action to take in an emergency.
4. Can take the medication without assistance.

Participants who do not meet all of these requirements may receive assistance with their medications provided:
1. The individual who is assisting is an adult who has successfully completed and follows the approved ”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.
2. The participant’s health condition is stable.
3. The participant’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.
4. The medication is in the original pharmacy-dispensed container with proper labeling and directions or is 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.
5. 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 individual assisting with the participant’s medications.
6. 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.
7. Procedures for disposal/destruction of medications must be documented and consistent with procedures outlined in the ”Assistance with Medications” course.
The Primary Care Physician specifies the frequency of review of participant medications. This review must occur at least annually. The Plan Monitor~~/Service Coordinator~~ must monitor the plan of service at least every ninety (90) days. This monitoring includes a review of participant medications when warranted by the participant's health status.

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.

Although the State does not use a second line monitoring mechanism to oversee the use of behavior modifying medications, processes are in place to:
• Routinely monitor a provider's compliance with assisting the participant with taking their medications as prescribed.
• Complete a clinical review of plans to ensure formal or informal services or natural supports are in place to provide assistance to the participant (as applicable), when behavior modifying medications have been prescribed by a health care practitioner. This need is verified through a review of a "Physician's History and Physical, the Medical, Social and Developmental Assessment, and the Nursing Services and Medication Administration" form. Each of these forms is required to be updated and submitted to the Department on an annual basis to be used in the plan review process.
• Investigate any critical incident report received on a participant that relates to health and safety. This includes any concerns related to improper administration or assistance of behavior modifying medications.

Identification of issues or problems with participant medications is accomplished in several ways. These include:
1. Participant medications are listed on the "Medical, Social and Developmental Assessment Summary" form and are updated annually by the Independent Assessment Contractor (IAC). Any changes to medications or problems with medications over the past year should be identified on this form.
2. Annually, the participant's service plan is reviewed by Department staff prior to authorization. The plan is required to include updates from Provider status reviews and identifies any documented or anticipated health & safety issues.
3. The Plan Monitor is required to monitor the plan of service at least every ninety (90) days. As outlined in IDAPA 16.03.10.513.05, plan monitoring must include the following: face-to-face contact with the participant to identify the current status of programs and changes if needed; contact with service providers to identify barriers to service provision; discussion with participant regarding quality and quantity of services.
4. For participants receiving Residential Habilitation through an agency, the agency is required to review the participant's programs (including assistance with medications, if applicable) at least quarterly or more often if required by the participant's condition.
5. For participants receiving services through a Certified Family Home (CFH), CFHs are re-certified annually by the Department. The re-certification process includes review of compliance with rules and regulations including handling of and assisting with resident medications.
6. Ongoing waiver provider Quality Assurance (QA) reviews include review of requirements for handling and assisting with participant medications, if applicable. Subsection 705.01, of IDAPA 16.03.10, outlines the requirements for staff assisting with medications.
7. Monitoring of Complaint/Critical Incident Reporting for incidents involving participant medications. The Department is responsible for the follow-up and oversight of potentially harmful medication practices. When these practices are identified through any of the above-listed mechanisms, the Department follows up as appropriate. This follow-up may include requiring changes to the plan of service, referrals to appropriate licensing or certification authorities, and/or provider sanctions.

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).

The Idaho Board of Nursing Administrative Rules distinguishes between assistance with medications and administration of medications. These terms are defined in IDAPA 24.34.01, "Rules of the Idaho Board of Nursing" as:

- Assistance with Medications: The process whereby a non-licensed care provider is delegated tasks by a licensed nurse to aid a patient who cannot independently self-administer medications.
- Administration of Medications: The process whereby a prescribed medication is given to a patient by one (1) of several routes. Administration of medication is a complex nursing responsibility which requires knowledge of anatomy, physiology, pathophysiology and pharmacology. Only persons authorized under Board statutes and these rules may administer medications and treatments as prescribed by health care providers authorized to prescribe medications.

Only a licensed nurse or other licensed health professionals working within the scope of their license may administer medications. Administration of medications must comply with IDAPA 24.34.01, “Rules of the Idaho Board of Nursing.” Due to this limitation, the only waiver service providers qualified to administer medications are Skilled Nurses. The requirement for assisting participants with medications is outlined in Appendix G-3-b-i.

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

Providers must maintain a comprehensive medication log that includes any medication errors as defined by the professional licensing board and best practice guidelines.

Medication administration under the scope of the Nurse Practice Act (Idaho Statute, Title 54 – Chapter 14, "Nurses") 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 Department conducts regular Quality Assurance (QA) reviews of waiver service providers and responds to complaints and reports of critical incidents on an ongoing basis. QA reviews include checks that nursing providers maintain current licensure and are not subject to any sanctions by the Idaho Board of Nursing.

Providers are required to record but not report medication errors unless requested by the state. Medication errors are reviewed when reported to the Department through the Complaint and Critical Incident reporting system.

Data related to medication errors is collected if identified as a complaint on the Complaint and Critical Incident Reporting System. If a trend or pattern is identified, the Department's Quality Improvement Specialist reviews provider records and discusses complaint and remediation with the provider agency as appropriate, which helps to prevent re-occurrence. Complaints or Critical Incidents beyond the jurisdiction of the Department are referred to the appropriate agency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
 # and % of participants or a legal guardian (LG) who received information/education on reporting abuse, neglect, exploitation (A/N/E) & other critical incidents (CI) as specified in the approved waiver. a. Num: # of participants (or a LG) who received information/education on reporting A/N/E & other CI as specified in the approved waiver. b. Den: # of participants receiving waiver services.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number of substantiated instances of abuse, neglect, exploitation and unexplained death that were remediated. a. Numerator: Number of substantiated instances of abuse, neglect, exploitation and unexplained death that were remediated. b. Denominator: Number of substantiated instances of abuse, neglect, exploitation and unexplained death.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
No. & % of reported instances of abuse/neglect/exploitation (A/N/E) & unexplained death that were reported by mandatory reporters within required timeframes. Num: No. of reported instances of A/N/E & unexplained death that were reported by mandatory reporters within required timeframes. Den: No. of reported instances of A/N/E & unexplained death that were reported by mandatory reporters.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of reported instances of abuse, neglect, exploitation and unexplained death that were investigated. a. Numerator: Number of reported instances of abuse, neglect, exploitation and unexplained death that were investigated. b. Denominator: Number of reported instances of abuse, neglect, exploitation and unexplained death.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number & percent of substantiated incident reports reviewed that indicate a resolution was achieved. a. Numerator: Number of substantiated instances of abuse, neglect, exploitation, and unexplained death that indicated a targeted resolution was achieved. b. Denominator: Number of substantiated instances of abuse, neglect, exploitation, and unexplained death received in the reporting period.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
 # & percent of substantiated instances of abuse, neglect, exploitation (A/N/E), & unexplained death resulting in targeted/systemic preventative measures. a. Numerator – # of substantiated instances of A/N/E & unexplained death resulting in targeted/systemic preventative measures. b. Denominator – # of substantiated instances of A/N/E & unexplained death received in the reporting period.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
 # and % of service plans with restrictive interventions (including restraints/seclusion) that were approved according to criteria in approved waiver. a. Num: Number of service plans with restrictive interventions (including restraints/seclusion) that were approved according to criteria in approved waiver. b. Den: Number of service plans with restrictive interventions that were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Services Outcome Review (record reviews and participant interviews)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
 # and % of service plans with restrictive interventions (including restraints/seclusion) used according to policies & procedures in approved waiver. a. Num: # of service plans with restrictive interventions (including restraints/seclusion) used according to policies & procedures in approved waiver. b. Den: # of service plans with restrictive interventions that were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Adult Services Outcome Review (record reviews and participant interviews)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% Confidence Level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants who received an annual wellness examination. a.
Numerator: Number of participants who received an annual wellness examination. b.
Denominator: Number of participants receiving waiver services.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

The Department ensures an effective system for assuring participant health and welfare is in place and that any applicable performance metrics are met. The Department records all incidents of abuse, neglect, exploitation, and unexplained death in the Complaint and Critical Incident database. Quality Assurance (QA) staff thoroughly investigate each incident. If any deficiency is identified, the Department notifies the provider of the deficiencies and the actions required to remediate the issue. If the provider fails to remediate the issue the Department addresses those areas with the provider via the corrective action process. For deficiencies requiring immediate resolution, the Department addresses those via the corrective action process.

The Medicaid Bureau of Developmental Disabilities Services (BDDS) Quality Manager is responsible for QA remediation and system improvement processes and reporting.
The BDDS Quality Oversight Committee, (comprised of BDDS Bureau Chief, BDDS Quality Manager, BDDS Operations Manager, Medicaid Contract Monitors, State Licensing & Certification (L&C) Staff and Medicaid Policy Staff) reviews data and the Annual BDDS Level of Care (LOC) Report findings, identifies remediation activities, and monitors ongoing system improvement initiatives and activities.

The BDDS Management Team identifies and addresses any statewide resource or program issues identified in QA business processes and reviewed and analyzed reports analyzed. Recommended program changes or system improvement processes are sent to the Medicaid Central Office Management Team (COMT) for approval. COMT reviews BDDS and other Medicaid program report analyses and recommendations, considers Division-wide resources and coordination issues and strategies when making final system-wide change decisions.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Medicaid Bureau of Developmental Disability Services (BDDS) Quality Assurance (QA) Management Team includes:
• BDDS Bureau Chief
• BDDS Quality Manager
• BDDS Operations Managers
• Medicaid Policy Staff
• Medicaid Contract Monitors
• State Licensing & Certification (L&C) Staff

This team reviews Quality Improvement (QI) Strategy findings and analysis (including trending), formulates Continuous Quality Improvement (CQI)/remediation recommendations, and identifies and addresses any statewide resource or program issues identified in QA business processes.

Recommended program changes or system improvement processes are then referred to the Central Office Management Team (COMT) for review and approval. COMT reviews BDDS QI recommendations. COMT prioritizes recommendations taking into consideration division-wide resources, coordination issues, and strategies. Based on prioritization, COMT makes final remediation decisions and implements system-wide change.

In addition, the BDDS Self-Direction Quality Oversight Committee includes:
• BDDS Quality Manager
• BDDS Operations Manager
• Medicaid Policy Staff
• BDDS Quality Assurance Staff
• BDDS Care Managers
• Support Brokers
• Community Support Workers
• Self-Advocates

This team reviews information related to consumer directed services including data collected from QA processes. The Self-Direction Quality Oversight Committee formulates recommendations for program improvement to the QA Management Team.

The BDDS Quality Manager leads QA Team members and oversees the QA tasks for both traditional and consumer directed services. The Quality Manager finalizes quarterly and yearly Quality Management reports, leads the process of prioritizing needs for system improvements, and implements approved system improvements.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system

design changes. If applicable, include the state's targeted standards for systems improvement.

When the Central Office Management Team (COMT) identifies system-wide changes, The Bureau of Developmental Disability Services (BDDS) Quality Assurance QA Management Team monitors and analyzes the effectiveness of the design change.

The BDDS QA Management Team as described in H-1-i implements QA-related activities as defined in the Quality Improvement (QI) strategy.

All design changes are tracked through a Continuous Quality Improvement (CQI) task list. This Task List identifies:
• The description of a task,
• The implementation plan,
• The monitoring plan, and
• The outcome.

QI tasks are monitored on a quarterly and annual basis and updates are given to COMT.

There are several methods the Department uses to communicate policy changes and other important updates to the public. Information Releases (IR) are issued to providers and/or participants to provide updates on policy, billing, or processing changes. IRs are often sent out to a specific group of providers or participants who may be directly impacted by any specific changes.

The Department also publishes a MedicAide newsletter. The MedicAide newsletter is a monthly publication that incorporates any IRs that were issued the previous month and communicates information to Medicaid providers and other interested parties. The Department publishes historical IRs and MedicAide Newsletters on the Department's website on the "Information for Medicaid Providers" page (https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers), ~~as well as on~~ the Medicaid Medical Information System (MMIS) Contractor's website (idmedicaid.com), and for self-direction providers, on the Department's website here: https://healthandwelfare.idaho.gov/providers/home-and-community-based-services-adult-developmental-disabilities/self-direction under "Provider Information and Links"~~.~~

In addition, state law requires that the public receive notification when a state agency initiates proposed rulemaking procedures and be given an opportunity to comment on that rulemaking. Notification of a proposed rulemaking is provided through a Legal Notice that publishes in local newspapers and the Department's website whenever a proposed rulemaking is published in the Bulletin.

The state assures that on a quarterly basis the QA Management Team reviews unduplicated participant counts as part of the Bureau's quarterly QA Meetings. As part of this monitoring, the BDDS Quality Manager analyzes the effectiveness of this review and recommends remediation as necessary.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Bureau of Developmental Disability Services (BDDS) Quality Manager is responsible for the management and oversight of BDDS's Quality Assurance (QA) system.

These duties include:
• Implementation and monitoring of Quality Improvement (QI) strategy,
• Training and oversight of the BDDS QA Team,
• Related data collection.
• Reporting.
• Monitoring of unduplicated number of waiver participants on a quarterly basis. and
• Continuous QI and remediation processes and activities.

As part of quarterly monitoring activities, the Quality Manager evaluates the QI strategy for effectiveness and recommends changes as needed.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The Department authorizes all reimbursable services under this Home and Community Based Services (HCBS) Waiver Program before the services are rendered.

Medicaid staff enter prior authorizations for approved services into the Medicaid Management Information System (MMIS). The prior authorization number must appear on the claim, or it will be denied. Approved prior authorizations are valid for one (1) year from the date of prior authorization by Medicaid unless otherwise indicated. Claims are adjudicated by the MMIS in accordance with federal guidelines and Idaho policies. This includes extensive claim edit and audit processing, claim pricing, and claim suspense resolution processing.

The Medicaid Program Integrity Unit (MPIU) processes support the post-payment analysis of expenditures to identify potential misuse, abuse, and quality of care in Medicaid. Functions specifically supported by these processes include the traditional surveillance and utilization review features of the MMIS, retrospective drug utilization review.

Providers are selected for post-payment audits performed by the Medicaid Program Integrity Unit based on:

- *Referrals from Medicaid program staff, Welfare Fraud, Managed Care Entities (MCE), Dual Plan providers, the Medicaid Fraud Control Unit (MFCU), the Office of Inspector General, or other agencies;*
- *Complaints from participants, competitors, parents, neighbors, and other stakeholders;*
- *Data mining;*
- *Quarterly Utilization Report Reviews – outliers are identified and reviewed to determine reasons why the provider's billing is different than peers; and*
- *Special Studies – The state may initiate audits based on a special study of a specific program, type of service or specific code.*

The frequency of post-payment audits performed by the MPIU varies based on the number of complaints/referrals received and the amount of data mining, reviews and special studies conducted.

The audited criteria from provider records are determined by the type of audit conducted. For example, a criminal history and background check audit consists of reviewing employee information. An audit of services consists of verifying that authorized services were provided, all documentation requirements were met, services were billed with appropriate codes and/or modifiers, providers did not exceed the authorized services, and that services were provided by qualified individuals.

The scope of post-payment audits performed by the MPIU depends on the allegations or concerns. A decision regarding scope is made on a case-by-case as to the period of time to audit, how many participant records will be reviewed, and whether a probe sample is necessary or if an audit needs to be based on a statistical sample. RAT-STATS is used for statistical sampling.

Historically, on-site audits are conducted based on a variety of reasons, including:

- *There is a large quantity of records needed and it could be an administrative and/or financial burden on the provider if we requested that the provider pull, copy, and mail the requested records.*
- *When there is a business need to obtain records quicker than requesting them through the mail, which allows thirty (30) days to produce the records.*
- *When there is concern about the integrity of the records, which allows the provider thirty (30) days to produce the records.*
- *When there is a need to visit the provider's office to talk with staff, meet with owners, observe services.*

Except for providers of participant-directed services, providers receive notification of overpayments and overpayments are recouped. For participant-directed services a notice of identified overpayments is not sent to anyone, and overpayments are not recovered.

The results of post-payment audits performed by the MPIU are communicated to providers as follows:

- *MPIU contacts providers to discuss preliminary findings and sends written notice of the findings.*
- *Providers receive an opportunity to dispute the findings and provide additional information and/or records. When the additional information and/or records provided results in revised findings, the providers receive notice of the revised findings.*
- *If the auditor and the provider reach an impasse, the provider receives an opportunity to discuss the audit with Department management before the audit is finalized.*

• If the provider still disputes the findings, an Administrative Action notice is sent detailing the results of the audit and requesting repayment of identified overpayments. This notice includes the provider's appeal rights.

• On appeal, the provider can present their case to an Administrative Hearing Officer. The Hearing Officer issues a preliminary order, and the provider can appeal the Hearing Officer's decision to the Director and/or District Court and then to judicial review.

MPIU asks providers to explain why rules were violated but does not require providers to submit corrective action plans.

The state recoups and removes inappropriate claims from claims for Federal Financial Participation (FFP) as follows:

• The state tracks Medicaid overpayments on an Audit Settlement Tracker. The settlement is entered on the tracker per the audit report date.

• If a provider pays within 365 days, the return is reported on form, 64.9C1 – Fraud, Waste & Abuse Recoveries from State Medicaid Program Integrity Activities.

• If the provider does not pay within 365 days, funds are returned on form 64.9O – Medicaid Overpayment Adjustments.

• When funds are collected the State reclaims and returns on form 64.9 OFWA – Fraud, Waste, and Abuse Amounts Overpayments for a net impact of zero (0) since the funds were previously returned.

The Department conducts performance monitoring of the Medicaid Management Information System (MMIS) contract to ensure that claims are adjudicated by the MMIS in accordance with federal guidelines and Idaho policies. In addition, Idaho participates in the Payment Error Rate Measurement (PERM) Program.

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 State requires the MMIS 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).

Idaho's Legislative Services Office (LSO), Legislative Audit Division performs annual Single Audit reviews of the Medical Assistance Program (CFDA 93.778).

The State requires other providers to secure an independent audit of their financial statements. Medicaid contracted vendors that meet service organization standards are required to pay for an independent, certified public accounting firm to perform an attestation of the Contractor's internal controls in accordance with the American Institute of Certified Public Accountants Statement Standards for Attestation Engagement (SSAE) No. 18, Attestation Standards: Clarification and Recodification. The Contractor shall initially and annually provide a copy of its most recent Service Organization Control (SOC) Type 2 report(s) on controls as a service organization and tests of operating effectiveness.

Electronic Visit Verification (EVV).
No services provided under this waiver require EVV compliance. The state's EVV system certification with CMS in March of 2021 included an analysis of these services.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
Number & percent of service delivery records demonstrating claims for waiver services are coded & paid in accordance with reimbursement methodology in approved waiver. a. Num: # of service delivery records demonstrating claims for waiver services are coded & paid in accordance with reimbursement methodology in approved waiver. b. Den: # of service delivery records reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Ad Hoc Paid Claims Reports and Service Delivery Records

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% Confidence Level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and***	☐ ***Other***

	Ongoing	*Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of claims paid according to the posted fee schedule. a. Numerator: Number of claims paid according to the posted fee schedule. b. Denominator: Paid claims (by procedure code) for one week of each calendar quarter.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Ad-hoc paid claims report

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid***	☐ ***Weekly***	☒ ***100% Review***

Agency		
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

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 (by procedure code) 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 posted rates (by procedure code) derived from rate methodologies in the approved waiver.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Bureau of Financial Operations – Financial Report

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

	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

Medicaid's Medicaid Management Information System (MMIS) requires prior authorization for all waiver services. Prior authorization includes a review process completed by Medicaid Bureau of Developmental Disabilities Services (BDDS) staff to ensure the correct service is authorized for the correct participant and by the correct provider.
The MMIS is designed to reduce instances of individual problems by processing payment for claims as prior authorized.

If any deficiency is identified, the Department notifies the provider of the deficiencies and the actions required to remediate the issue, including claim reversal. If the provider fails to remediate the issue the Department addresses those areas with the provider via the corrective action process and/or referral to the Medicaid Program Integrity Unit.

The BDDS Quality Manager is responsible for Quality Assurance (QA) remediation and system improvement processes and reporting.

The BDDS QA Team identifies and addresses any statewide resource or program issues identified in QA business processes and analyses reports. These results are reported to the BDDS Quality Manager. Recommended program changes or system improvement processes are sent to the Medicaid Quality Management Oversight Committee for approval.

The BDDS Quality Oversight Committee (comprised of BDDS Bureau Chief, BDDS Quality Manager, BDDS Operations Managers, Medicaid Contract Monitors, Department Licensing and Certification (L&C) staff, and Medicaid Policy Staff) reviews data, identifies remediation activities, and monitors ongoing system improvement initiatives and activities.
BDDS Management Team identifies and addresses any statewide resource or program issues identified in QA business processes and analyzes reports and recommends program changes or system improvement processes are sent to the Medicaid Central Office Management Team (COMT) for approval.

COMT reviews BDDS and other Medicaid program report analyses and recommendations and considers Division-wide resources and coordination issues and strategies when making final system-wide change decisions.

The Department uses the following strategies to ensure financial oversight with claims and billing:
• MMIS personnel review system-level audits to prevent duplicate transactions from being paid more than once, regardless how many times the service is billed and submit yearly audit reports to the Department.
• MMIS ensures that claims are adjudicated by the system in accordance with Federal guidelines and Idaho policies.
• The State requires the MMIS to contract with and pay for an independent Certified Public Accounting (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).
• Corrective actions are submitted when appropriate.
• Possible provider fraudulent billing patterns that are identified during the following Quality Improvement processes are investigated and forwarded to the Medicaid Fraud Control Unit. They are tracked and trended for analysis and provider corrective actions in the Division's Medicaid Complaint/Critical Incident Tracking tool.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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)). Pursuant to 42 CFR §447.205, the State publishes public notice of proposed reimbursement changes in multiple newspapers throughout the State and on the Department's website at www.healthandwelfare.idaho.gov. Copies of public notices and text of proposed significant reimbursement changes are made available for public review on Department's website and during regular business hours at agency locations in each Idaho county as identified in each public notice. Additionally, payment rates are published on the Department's website at for the public to access.

The Adult Developmental Disabilities Waiver Services fee schedule is found in the Provider Resources folder under > Medicaid > Fee Schedules > Provider Reimbursement Rates folder located at: https://publicdocuments.dhw.idaho.gov/WebLink/Browse.aspx?id=3488&dbid=0&repo=PUBLIC-DOCUMENTS. Select the link for year desired to view waiver provider rates by that year.

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 thirty (30) days prior to the submission of any 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 at least twenty-one (21) days after the date of publishing 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 state collaborates with providers on rate reviews for the services outlined below through direct outreach via email or phone, meetings and Information Releases. Oversight of the rate determination process is conducted by a third-party accounting firm, a provider workgroup, legislative joint finance committee and state Medicaid staff. The Bureau of Financial Operations is responsible for rate determinations. Main Section 6-I describes the state's process for soliciting public comments on rate determination methods.

Review and rebasing reimbursement rates are initiated through cost surveys and/or when an access or quality indicator reflects a potential issue as outlined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" Sections 037-038. Rebasing is finalized through the approval of Idaho budget requests as authorized by the Idaho State Legislature. Providers and participants with questions about pricing should contact Medicaid's Office of Reimbursement by phone (208) 287-1180 or email MedicaidReimTeam@dhw.idaho.gov.

Service Rate Methodology Information:
A. General Rate Provisions.
1. The state reimburses services at the same rate statewide, and
2. Rates may vary by provider type under this waiver. Differences are indicated by provider type on the published Adult Developmental Disabilities Waiver Services Fee Schedule.
Differences are driven by provider-specific cost surveys that review wage and cost data collected from providers directly, the Bureau of Labor Statistics, and the Internal
Revenue Service.
B. Fee-For-Service Rates.
1. Rates Developed by the Cost Survey Model.
a. Adult Day Health. Rates were last reviewed and rebased SFY 2023~~2~~.
b. Residential Habilitation. Rates were last reviewed SFY 2023~~2~~ and last rebased SFY 2019~~8~~. Rates for Residential Habilitation vary by level of Supported Living and/or Certified
Family Home (CFH) service provided, but do not vary by provider type.
c. Supported Employment Services. Rates were last reviewed and rebased SFY 2023~~0~~.
d. Behavioral Consultation/Crisis Management. Rates were last reviewed SFY 2022~~0~~ and rebased SFY 2008. Rates vary by provider qualifications as indicated on the published fee
schedule.
e. Respite Care. Rates were last reviewed in SFY 2023 and rebased SFY 2024~~2~~. Rates vary by unit~~provider~~ type as indicated on the published fee schedule.

2. Manually Priced Rates.
a. Chore Services. Items are manually priced based on the submitted invoice price.

b. Environmental Accessibility Adaptations. for adaptations over $500, three (3) bids are required if it is possible to obtain three (3) bids. The lowest bid which meets the participant's needs is selected.

c. Specialized Medical Equipment and Supplies. For equipment and supplies 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 is seventy-five percent (75%) of MSRP. If pricing documentation is the invoice, reimbursement is at cost plus ten percent (10%), plus shipping (if that documentation is provided). For equipment and supplies that are not manually priced, the rate is based on the published Medicaid fee schedule price.

d. Transition Services. Service is manually priced; projected amount for this benefit is calculated based on an average of actual expenses for this service over the previous waiver cycle (for this renewal, actual expenses were averaged for waiver years 2 through 5 (FFY2019 through FFY2022) of the previous waiver cycle as Transition Services was not added to this waiver until FFY 2019).

3. Other Rate Models.

a. Home Delivered Meals. The initial rate was set in 1999 based on time studies in nursing facilities. Rates related to Home Delivered Meals were last reviewed SFY 202~~1~~0 and rebased SFY ~~2011~~2023.

b. Non-Medical Transportation (NMT). A study was conducted evaluating the actual costs of fuel reasonably incurred by the typical non-commercial transportation provider whose personal vehicle averages fifteen (15) miles per gallon. Rates vary by provider type and service offered as indicated on the published fee schedule. Rates were last reviewed in SFY 2023 and rebased SFY 2010.

c. Personal Emergency Response System (PERS). The rate was developed by surveying PERS vendors in all seven (7) regions of the State to calculate a state-wide average. The state-wide average is the rate paid for this service. Rates were last reviewed in SFY 2022 and rebased SFY ~~2011~~2023.

d. Skilled Nursing. These services are paid on a uniform reimbursement rate based on an annual survey conducted by the Department. Rates were last reviewed SFY 2022 and rebased SFY ~~2014~~2023. Rates vary by provider type and license of direct care staff as indicated on the published fee schedule.

4.Self-Direction Rates.

a. Non-Medical Transportation, Skilled Nursing Services, Specialized Medical Equipment and Supplies, Support Broker Services, and Community Support Services. Rates are set by the participant based on the specific needs of the participant through negotiation with the Department. The identified rates may not exceed prevailing market rates, identified using Bureau of Labor and Statistics wage data, Medicaid reimbursement rates, and IRS standard mileage rates. The Department provides training and resource materials to assist the participant, Support Broker, and circle of supports to make this determination. The participant and their Support Broker monitor this requirement each time the participant enters into an employment agreement. The Department ensures that the proposed plan of service does not exceed the overall budget at the time of plan review and approval. The Department also reviews a statistically valid sample of participant employment agreements during the annual or bi-annual retrospective quality assurance reviews.

b. Financial Management Services (FMS). Reimbursement methodology for FMS is based on a market study of other state Medicaid program rates for FMS to gather a range which allows the Department to accept a Per Member Per Month (PMPM) rate within the range determined from the market study. ~~The established PMPM payment rates for each Department approved qualified FMS provider is published on a fee schedule by the Department. This fee schedule is updated at least yearly, and when new providers are approved. This information is published for consumer convenience the Department's website.~~

c. Transition Services. Rates are set by the participant based on the specific needs of the participant through negotiation with the Department. Expenses for Transition Services may not exceed $2,000 per qualifying transition.

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 participants selecting traditional waiver services, provider billing flows directly from the provider to the State's claim payment system. Health PAS Administrator (QNXT) is Idaho's Medicaid Management Information System (MMIS).

Participants who select consumer directed services use a Fiscal Employer Agent (FEA) to process provider billing. The FEA pays claims that have been approved on the Support and Spending Plan and then bills through the MMIS.

Electronic Visit Verification (EVV).
No services provided on this waiver require EVV compliance. The state's EVV system certification with CMS in March of 2021 included an analysis of these services.

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 Federal Financial Participation (FFP):

1. Participant financial eligibility is determined by the Division of Welfare. Once eligibility is determined, the participant's eligibility information is electronically transmitted to the State's Medicaid Management Information System (MMIS) from the Idaho Benefits Eligibility System (IBES). Claims are edited against the eligibility file in the MMIS to ensure that claims are paid for Medicaid eligible participants only.

2. Medicaid staff enter prior authorization of Medicaid reimbursable services as indicated on the approved service plan into the MMIS.

3. Explanation of Medicaid Benefits are generated monthly 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 sample size of participants that receive an Explanation of Benefits notice is 1% of the eligible participants with paid claims in the past month. 1% of the member population exceeds the threshold for a 95% Confidence Level.

4. Medicaid Program Integrity Unit (MPIU) identifies inappropriate claims during their audit process. Inappropriate claims are recouped by one of more of the following methods:
• Lump sum payments;
• Repayment agreements;
• Claim adjustments; and/or
• Payment offsets.

The State's Fiscal Unit adjusts the CMS-64 on a quarterly basis to remove inappropriate claims from FFP.

5. All claims are processed through the MMIS. The MMIS is managed and monitored by Medicaid.

6. Finally, during retrospective quality assurance reviews, Medicaid staff review participant files, provider employee files, and provider documentation of services. ~~participant progress notes and documentation of services~~. When staff discover inadequate documentation or inconsistent service delivery, they make a referral to MPIU for further investigation.

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:

Consumer Directed Services are paid through a qualified Financial Management Services provider chosen by the participant. The provider bills Medicaid through the Medicaid Medical Information System (MMIS) according to the participant's plan which is prior authorized by the Department. The Financial Management Services provider maintains records for each participant. These records indicate spending within the following categories:
1. Support Broker Services,
2. Community Support Services,
a. Job Support,
b. Personal Support,
c. Relationship Support,
d. Emotional Support,
e. Learning Support,
f. Transportation Support,
g. Adaptive Equipment, and
h. Skilled Nursing.
3. Financial Management Services

The Department enters into provider agreements with qualified providers to perform Financial Management Services for participants who select Consumer Directed Services. The Department monitors the activities of each Financial Management Services provider through the following methods:
• Auditing transactions selection of a random sample of participants. These audits include a review of records and transactions completed on behalf of participants. The audit methodology uses statistically valid standards to assure that the sample is random and of sufficient size to achieve statistical significance,
• Ensuring each Financial Management Services provider's quality of services through internal quality assurance activities;
• Obtaining assessments of participant satisfaction with their Financial Management Services provider as part of regular participant experience surveys; and
• Conducting formal assessments of each Financial Management Services provider occurs at least every two (2) years.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- (●) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ( ) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

- ( ) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state***

Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***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.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The following is the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

1. As indicated in the rate determination method, payment for room and board in residential settings is not used to derive the Medicaid rate. 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.

Residential settings must provide room, utilities and three (3) daily meals (room and board) to the resident. The charge for room and board must be established in the residential setting's admission agreement. As outlined in 16.03.19.260.04, at the time of admission, the provider and the resident must enter into an admission agreement. The agreement must be in writing and be signed by both parties. The agreement must, in itself or by reference to the resident's plan of care, include the amount charged for room and board. The participant's plan of care, including admission records, must be authorized by the Department prior to admission.

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.
The Room and Board allowance is 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 is effective on January 1st of each year. The room and board allowance increase is rounded up to the next 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: ICF/IID

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	67505.97	26939.09	94445.06	100071.92	21505.18	121577.10	27132.04
2	76962.81	27651.89	104614.70	101245.07	24240.64	125485.71	20871.01
3	87653.20	28886.81	116540.01	101510.47	26345.57	127856.04	11316.03
4	93455.09	29900.82	123355.91	103301.63	28824.11	132125.74	8769.83
5	99842.11	30794.76	130636.87	103922.52	31605.47	135527.99	4891.12

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:	
		ICF/IID	
Year 1	7458		7458
Year 2	7458		7458
Year 3	7458		7458
Year 4	7958		7958
Year 5	8492		8492

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 Average Waiver Length of Stay (ALOS), Medicaid Management Information System (MMIS) data for this waiver and used to generate the CMS-372 reports for the previous three (3) years spanning Federal Fiscal Year (FFY) 2018 through FFY 2021 was used. ALOS has remained consistently stable over prior waiver periods. At this time, the state has no reason to expect ALOS to vary significantly over the upcoming waiver period. Days are limited to 365.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Historical waiver expenditure data and user data from the state's Medicaid Management Information System (MMIS) used to generate 372 reports were used to assist in projecting forward the estimate for the five (5) year waiver period. This data spanned Federal Fiscal Year (FFY) 2018 through FFY 2021. MMIS data was similarly used in projecting the self-direction services.

The estimated number of users of each service was calculated by reviewing the number of users of each service available in the MMIS data used to generate the CMS 372 reports and increasing that number at the same rate that the overall number of waiver participants is expected to increase during the five (5) year waiver period including for self-directed participants.

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 Adult DD waiver participants from the internal Medicaid Management Information System (MMIS) system were used to as the basis for projecting forward over the five-year estimate period. A linear trend of the historical MMIS data spanning FFY 2017 through FFY 2021 was the basis for the first waiver year. Subsequent waiver years were estimated along a rolling five-year linear regression that incorporated the proceeding waiver year estimates.

A rolling five-year linear regression was used instead of using a static estimate for all annual growth factors for D' prime to align the projection methodology utilized across D', G, and G'. Additionally, it incorporates MMIS data to drive the trend rather than annual growth factors of the program. No adjustments were made due to the Public Health Emergency because a rolling five-year linear regression was used that incorporated multiple years of data instead of using a static estimate.

The state did not include the cost of prescribed drugs furnished to Medicare/Medicaid dual eligibles under the provision of Part D when estimating Factor D'.

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:*

Historical Medicaid expenditures for Adult DD waiver participants from the internal Medicaid Management Information System (MMIS) system were used to as the basis for projecting forward over the five-year estimate period. A linear trend of the historical MMIS data spanning FFY 2017 through FFY 2021 was the basis for the first waiver year. Subsequent waiver years were estimated along a rolling five-year linear regression that incorporated the proceeding waiver year estimates.

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:*

Historical Medicaid expenditures for Adult DD waiver participants from the internal Medicaid Management Information System (MMIS) system were used to as the basis for projecting forward over the five-year estimate period. A linear trend of the historical MMIS data spanning FFY 2017 through FFY 2021 was the basis for the first waiver year. Subsequent waiver years were estimated along a rolling five-year linear regression that incorporated the proceeding waiver year estimates.

A rolling five-year linear regression was used instead of using a static estimate for all annual growth factors for D' prime to align the projection methodology utilized across D', G, and G'. Additionally, it incorporates MMIS data to drive the trend rather than annual growth factors of the program. No adjustments were made due to the Public Health Emergency because a rolling five-year linear regression was used that incorporated multiple years of data instead of using a static estimate.

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	
Residential Habilitation	
Respite	
Supported Employment	
Financial Management Services	
Support Broker Services	
Adult Day Health	
Behavior Consultation/Crisis Management	
Chore Services	

Waiver Services	
Community Support Services (Participant Direction)	
Environmental Accessibility Adaptations	
Home Delivered Meals	
Non-Medical Transportation	
Personal Emergency Response System	
Skilled Nursing	
Specialized Medical Equipment and Supplies	
Transition Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						367364030.40
Residential Habilitation	15 minute	4187	21664.00	4.05	367364030.40	
Respite Total:						36945.90
Respite Daily	Per diem	1	18.00	53.39	961.02	
Respite Hourly	15 minute	9	1886.00	~~2.12~~5.77	35984.88	
Supported Employment Total:						5215817.46
Supported Employment	15 minute	499	1214.00	~~8.61~~11.92	5215817.46	
Financial Management Services Total:						4166569.20
Financial Management Services	Per member per month	1943	20.00	107.22	4166569.20	
Support Broker Services Total:						1969735.68
Support Broker Services	15 minute	1943	66.00	15.36	1969735.68	
Adult Day Health Total:						3991301.46
Adult Day Health	15 minute		906.00	2.79	3991301.46	

GRAND TOTAL:	503459540.37
Total Estimated Unduplicated Participants:	7458
Factor D (Divide total by number of participants):	67505.97
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1579				
Behavior Consultation/Crisis Management Total:						**13906.20**
Behavior Consultation/Crisis Management	15 minute	22	49.00	12.90	**13906.20**	
Chore Services Total:						**500.00**
Chore Services	Per chore	1	1.00	500.00	**500.00**	
Community Support Services (Participant Direction) Total:						**119585432.40**
Community Support Services (Participant Direction)	Per week	1943	68.00	905.10	**119585432.40**	
Environmental Accessibility Adaptations Total:						**13448.48**
Environmental Accessibility Adaptations	Per Job	2	2.00	3362.12	**13448.48**	
Home Delivered Meals Total:						**291457.44**
Home Delivered Meals	Per meal	162	344.00	~~5.23~~7.06	**291457.44**	
Non-Medical Transportation Total:						**125482.29**
Non-Medical Transportation	Per mile	163	383.00	2.01	**125482.29**	
Personal Emergency Response System Total:						**1477.75**
PERS Landline Install and First Month's Rent	One-Time Only	1	1.00	~~56.89~~67.13	**56.89**	
PERS Landline Monthly Rent	Per month	7	6.00	~~33.83~~39.92	**1420.86**	
Skilled Nursing Total:						**549654.01**
Skilled Nursing	15 minute	132	54.00	6.30	**44906.40**	
Nursing Oversight	15 minute	467	29.00	37.27	**504747.61**	
Specialized Medical Equipment and Supplies Total:						**126667.68**
Specialized Medical Equipment and Supplies	Piece of equipment	19	3.00	2222.24	**126667.68**	
Transition Services						**7114.02**

GRAND TOTAL:	**503459540.37**
Total Estimated Unduplicated Participants:	**7458**
Factor D (Divide total by number of participants):	**67505.97**
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Transition Services	Per Transition	6	1.00	1185.67	7114.02	
				GRAND TOTAL:		503459540.37
				Total Estimated Unduplicated Participants:		7458
				Factor D (Divide total by number of participants):		67505.97
				Average Length of Stay on the Waiver:		345

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						418329457.20
Residential Habilitation	15 minute	4468	23118.00	4.05	418329457.20	
Respite Total:						43690.01
Respite Daily	Per diem	1	19.00	53.39	1014.41	
Respite Hourly	15 minute	10	2013.00	~~2.12~~5.77	42675.60	
Supported Employment Total:						5931773.40
Supported Employment	15 minute	532	1295.00	~~8.61~~11.92	5931773.40	
Financial Management Services Total:						4667608.26
Financial Management Services	Per member per month	2073	21.00	107.22	4667608.26	
Support Broker Services Total:						2228889.60
Support Broker Services	15 minute	2073	70.00	15.36	2228889.60	
Adult Day Health Total:						4546012.05
Adult Day Health	15 minute	1685	967.00	2.79	4546012.05	
				GRAND TOTAL:		573988608.72
				Total Estimated Unduplicated Participants:		7458
				Factor D (Divide total by number of participants):		76962.81
				Average Length of Stay on the Waiver:		345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavior Consultation/Crisis Management Total:						15428.40
Behavior Consultation/Crisis Management	15 minute	23	52.00	12.90	15428.40	
Chore Services Total:						500.00
Chore Services	Per chore	1	1.00	500.00	500.00	
Community Support Services (Participant Direction) Total:						136967877.90
Community Support Services (Participant Direction)	Per week	2073	73.00	905.10	136967877.90	
Environmental Accessibility Adaptations Total:						13448.48
Environmental Accessibility Adaptations	Per Job	2	2.00	3362.12	13448.48	
Home Delivered Meals Total:						332057.93
Home Delivered Meals	Per Meal	173	367.00	~~5.23~~7.06	332057.93	
Non-Medical Transportation Total:						143043.66
Non-Medical Transportation	Per mile	174	409.00	2.01	143043.66	
Personal Emergency Response System Total:						1477.75
PERS Landline Install and First Month's Rent	One-Time Only	1	1.00	~~56.89~~67.13	56.89	
PERS Landline Monthly Rent	Per month	7	6.00	~~33.83~~39.92	1420.86	
Skilled Nursing Total:						626895.66
Skilled Nursing	15 minute	141	58.00	6.30	51521.40	
Nursing Oversight	15 minute	498	31.00	37.27	575374.26	
Specialized Medical Equipment and Supplies Total:						133334.40
Specialized Medical Equipment and Supplies	Piece of equipment	20	3.00	2222.24	133334.40	
Transition Services Total:						7114.02
Transition Services					7114.02	

GRAND TOTAL:	573988608.72
Total Estimated Unduplicated Participants:	7458
Factor D (Divide total by number of participants):	76962.81
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Per Transition	6	1.00	1185.67		
				GRAND TOTAL:		573988608.72
				Total Estimated Unduplicated Participants:		7458
				Factor D (Divide total by number of participants):		76962.81
				Average Length of Stay on the Waiver:		345

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						476368257.60
Residential Habilitation	15 Minute	4768	24669.00	4.05	476368257.60	
Respite Total:						51159.16
Respite Daily	Per diem	1	20.00	53.39	1067.80	
Respite Hourly	15 minute	11	2148.00	~~2.12~~5.77	50091.36	
Supported Employment Total:						6758643.36
Supported Employment	15 minute	568	1382.00	~~8.61~~11.92	6758643.36	
Financial Management Services Total:						5217754.08
Financial Management Services	Per member per month	2212	22.00	107.22	5217754.08	
Support Broker Services Total:						2548224.00
Support Broker Services	15 minute	2212	75.00	15.36	2548224.00	
Adult Day Health Total:						5176945.44
Adult Day Health	15 minute	1798	1032.00	2.79	5176945.44	
Behavior Consultation/Crisis						17737.50
				GRAND TOTAL:		653717550.88
				Total Estimated Unduplicated Participants:		7458
				Factor D (Divide total by number of participants):		87653.20
				Average Length of Stay on the Waiver:		345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Management Total:						
Behavior Consultation/Crisis Management	15 minute	25	55.00	12.90	17737.50	
Chore Services Total:						500.00
Chore Services	Per Chore	1	1.00	500.00	500.00	
Community Support Services (Participant Direction) Total:						156162333.60
Community Support Services (Participant Direction)	Per week	2212	78.00	905.10	156162333.60	
Environmental Accessibility Adaptations Total:						13448.48
Environmental Accessibility Adaptations	Per Job	2	2.00	3362.12	13448.48	
Home Delivered Meals Total:						379279.60
Home Delivered Meals	Per Meal	185	392.00	~~5.23~~7.06	379279.60	
Non-Medical Transportation Total:						163002.96
Non-Medical Transportation	Per mile	186	436.00	2.01	163002.96	
Personal Emergency Response System Total:						1477.75
PERS Landline Install and First Month's Rent	One-Time Only	1	1.00	~~56.89~~67.13	56.89	
PERS Landline Monthly Rent	Per month	7	6.00	~~33.83~~39.92	1420.86	
Skilled Nursing Total:						711672.21
Skilled Nursing	15 minute	150	62.00	6.30	58590.00	
Nursing Oversight	15 minute	531	33.00	37.27	653082.21	
Specialized Medical Equipment and Supplies Total:						140001.12
Specialized Medical Equipment and Supplies	Piece of equipment	21	3.00	2222.24	140001.12	
Transition Services Total:						7114.02
Transition Services	Per Transition	6	1.00	1185.67	7114.02	

GRAND TOTAL:	653717550.88
Total Estimated Unduplicated Participants:	7458
Factor D (Divide total by number of participants):	87653.20
Average Length of Stay on the Waiver:	345

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						542442873.60
Residential Habilitation	15 minute	5088	26324.00	4.05	542442873.60	
Respite Total:						59404.23
Respite Daily	Per diem	1	21.00	53.39	1121.19	
Respite Hourly	15 minute	12	2291.00	~~2.12~~5.77	58283.04	
Supported Employment Total:						7696048.50
Supported Employment	15 minute	606	1475.00	~~8.61~~11.92	7696048.50	
Financial Management Services Total:						5819901.60
Financial Management Services	Per member per month	2360	23.00	107.22	5819901.60	
Support Broker Services Total:						2899968.00
Support Broker Services	15 minute	~~2360~~3277	80.00	~~15.36~~5.11	2899968.00	
Adult Day Health Total:						5894765.01
Adult Day Health	15 minute	1919	1101.00	2.79	5894765.01	
Behavior Consultation/Crisis Management Total:						20549.70
Behavior Consultation/Crisis Management	15 minute	27	59.00	12.90	20549.70	
Chore Services Total:						500.00
Chore Services	Per Chore	1	1.00	500.00	500.00	
Community Support Services (Participant						177290988.00

GRAND TOTAL:	743715588.16
Total Estimated Unduplicated Participants:	7958
Factor D (Divide total by number of participants):	93455.09
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Direction) Total:						
Community Support Services (Participant Direction)	Per week	2360	83.00	905.10	177290988.00	
Environmental Accessibility Adaptations Total:						13448.48
Environmental Accessibility Adaptations	Per Job	2	2.00	3362.12	13448.48	
Home Delivered Meals Total:						430669.58
Home Delivered Meals	Per Meal	197	418.00	~~5.23~~7.06	430669.58	
Non-Medical Transportation Total:						185060.70
Non-Medical Transportation	Per mile	198	465.00	2.01	185060.70	
Personal Emergency Response System Total:						1477.75
PERS Landline Install and First Month's Rent	One-Time Only	1	1.00	~~56.89~~67.13	56.89	
PERS Landline Monthly Rent	Per month	7	6.00	~~33.83~~39.92	1420.86	
Skilled Nursing Total:						806151.15
Skilled Nursing	15 minute	160	66.00	6.30	66528.00	
Nursing Oversight	15 minute	567	35.00	37.27	739623.15	
Specialized Medical Equipment and Supplies Total:						146667.84
Specialized Medical Equipment and Supplies	Piece of equipment	22	3.00	2222.24	146667.84	
Transition Services Total:						7114.02
Transition Services	Per Transition	6	1.00	1185.67	7114.02	
				GRAND TOTAL:		743715588.16
				Total Estimated Unduplicated Participants:		7958
				Factor D (Divide total by number of participants):		93455.09
				Average Length of Stay on the Waiver:		345

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *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. 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	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Residential Habilitation Total:						***617627470.50***
Residential Habilitation	*15 minute*	*5429*	*28090.00*	*4.05*	***617627470.50***	
Respite Total:						***68586.34***
Respite Daily	*Per diem*	*1*	*22.00*	*53.39*	***1174.58***	
Respite Hourly	*15 minute*	*13*	*2446.00*	*~~2.12~~5.77*	***67411.76***	
Supported Employment Total:						***8768234.58***
Supported Employment	*15 minute*	*647*	*1574.00*	*~~8.61~~11.92*	***8768234.58***	
Financial Management Services Total:						***6749499.00***
Financial Management Services	*Per member per month*	*2518*	*25.00*	*107.22*	***6749499.00***	
Support Broker Services Total:						***3287500.80***
Support Broker Services	*15 minute*	*~~2518~~3660*	*85.00*	*~~15.36~~5.11*	***3287500.80***	
Adult Day Health Total:						***6713856.00***
Adult Day Health	*15 minute*	*2048*	*1175.00*	*2.79*	***6713856.00***	
Behavior Consultation/Crisis Management Total:						***23568.30***
Behavior Consultation/Crisis Management	*15 minute*	*29*	*63.00*	*12.90*	***23568.30***	
Chore Services Total:						***500.00***
Chore Services	*Per chore*	*1*	*1.00*	*500.00*	***500.00***	
Community Support Services (Participant Direction) Total:						***202834720.20***
Community Support Services (Participant Direction)	*Per week*	*2518*	*89.00*	*905.10*	***202834720.20***	
Environmental Accessibility Adaptations Total:						***13448.48***
Environmental Accessibility	*Per Job*	*2*	*2.00*	*3362.12*	***13448.48***	

GRAND TOTAL:	***847859210.84***
Total Estimated Unduplicated Participants:	***8492***
Factor D (Divide total by number of participants):	***99842.11***
Average Length of Stay on the Waiver:	*345*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adaptations						
Home Delivered Meals Total:						489841.80
Home Delivered Meals	Per Meal	210	446.00	~~5.23~~7.06	489841.80	
Non-Medical Transportation Total:						210358.56
Non-Medical Transportation	Per mile	211	496.00	2.01	210358.56	
Personal Emergency Response System Total:						1477.75
PERS Landline Install and First Month's Rent	One-Time Only	1	1.00	~~56.89~~67.13	56.89	
PERS Landline Monthly Rent	Per month	7	6.00	~~33.83~~39.92	1420.86	
Skilled Nursing Total:						909699.95
Skilled Nursing	15 minute	171	70.00	6.30	75411.00	
Nursing Oversight	15 minute	605	37.00	37.27	834288.95	
Specialized Medical Equipment and Supplies Total:						153334.56
Specialized Medical Equipment and Supplies	Piece of equipment	23	3.00	2222.24	153334.56	
Transition Services Total:						7114.02
Transition Services	Per Transition	6	1.00	1185.67	7114.02	

GRAND TOTAL:	847859210.84
Total Estimated Unduplicated Participants:	8492
Factor D (Divide total by number of participants):	99842.11
Average Length of Stay on the Waiver:	345